Hospice Insights: The Law and Beyond

Episode 31: COVID-19 Hospice How-To Series: Strategic Restructuring for the Future: The State of the Hospice Market

February 17, 2021

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Meg Pekarske	Hello and welcome to "Hospice Insights: The Law and Beyond," where we connect you to what matters in the ever-changing world of hospice and palliative care. "Strategic Restructuring for the Future: The State of the Hospice Market." Join me as I talk with Mark Kulik, Managing Director of The Braff Group, who shares his insights on growth and change in the hospice industry and the forces at work. We explore who are the disrupters, who is leaving the market and what matters to those who continue onward. Drawing parallels to the change that has occurred in other healthcare sectors, Mark opines on what the hospice market may look like in 5 and 10 years. I hope you enjoy the conversation and it leaves you with a new insight or perspective on where hospice is going. Welcome, Mark, I'm so glad to have you here with us. Thanks for making the time.
Mark Kulik	Thank you, Meg. Looking forward to this.
Meg Pekarske	Yeah me too, me too. And so as you know I'm kicking off this series to explore questions of change and – in the hospice industry and so I've been really looking forward to getting your insight on how things are going and maybe let's first start with your background as the managing director of The Braff Group. What is it that you do sort of day in and day out? And so we have the lens from which you're going to be sort of providing your insights to our audience.
Mark Kulik	Yeah thank you. So as managing director, my responsibility is to lead our firm's activity in the home health, the hospice, the private duty and the pediatric space. More specifically our firm, 95 percent of the time focuses on mergers and acquisitions. So we represent sellers when they decide to bring their company to market to sell and exit. We're the firm that represents them from start to finish, from beginning to the close.

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Meg Pekarske	So what brought you to The Braff Group or what was sort of your personal background and how did you land in hospice home health, pediatric, private duty, what attracted you?
Mark Kulik	Yeah it was a bit serendipitous how I got here but to start out with I got out of school and ended up having two offers. One was from IBM, one was from a company called American Hospital Supply Corporation, it doesn't exist anymore. I think it's mostly part of Baxter today. But at the time those were my two options and my dad was in the healthcare industry and I defaulted to the familiar. So I went to American Hospital Supply and we were focused on the hospital sector, manufacturing and distributing products to hospitals. And then in '84, if anyone remembers, DRGs have it and – hospitals, that's how old I am. The world changed. And almost overnight it wasn't about keeping the patient in the hospital, it was about getting the patient out of the hospital, getting the patient home. And that really struck me because I said that's pretty logical, you know people want to be at home more so than being in a hospital. So that kind of triggered my thoughts into the home healthcare world and shortly thereafter I joined a company that's now known as Apria. I started out in the – back then they called it the DME industry. That's again the dates may – the current phraseology, current....
Meg Pekarske	Well I still use DME Mark so I'm still with you as well so. But anyway so you – then you – so you moved to....
Mark Kulik	Yeah I got into that industry and spent a bunch of time there. I did well in that company. I got promoted. Got to the southeast and then I got involved in the software business that supports the HME industry as well as the home health industry and that gave me a peek into hearts of agencies, the good the bad and the ugly. And I got a chance to see how they work, how they don't work, how they used software, how they didn't use software. In fact around that time the biggest thing were handheld tablets and trios back at that point. That was a big advancement, taking something to the bedside in the home. And then from there I ended up working for a provider, for a pediatric provider where I started to do acquisitions for that provider and that led me to The Braff Group about 13 years ago. I was working on the buy side so to speak and love the transaction process and I got a chance to work with Dexter Braff and The Bragg Group about 13 years ago.
Meg Pekarske	So you used a word that is obviously a theme in this series which is "disruption," right. Because this is into the first disruption and....
Mark Kulik	No.

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Meg Pekarske	...and you know I think change has been a common occurrence to hospice I think from a regulatory perspective since 2008 when we got our rewrite of the hospice regs. There's been a lot of regulatory changes and I think the competitive landscape has obviously changed and there's been a lot of growth but I think the disruption we're really focusing on is, is our payment models are going to be changing because we're now going to be carved in at some point into Medicare Advantage but there also just is a lot more consolidation in the market and whatnot. And so you know I think this idea of disruption as sort of a bad thing, right? I mean I think we have to embrace it if you want to stay viable moving forward. It's like well what does this look like into the future and how do I grow into this future. And so I guess tell me, because obviously you've worked in this space for a long time and I know you keep a lot of data about the growth and change that you've seen in the industry over the last 5/10 years and how does that project outward. And so is what we saw in the past going to be what we'll see in the future? Do you think there's maybe fewer players? Like tell me what the data says cause I know you and I have talked about data before and it's really quite interesting.
Mark Kulik	Yeah so absolutely and I think the key theme there is I would call our industry maturing. We're maturing as an industry and as a result you change and you evolve and hopefully you learn from the past, you get smarter, you adapt. And I look at sister industries, like I came out of the home medical equipment industry and that was complete rental. Everything back then was rented everything. Nothing was bought by the government and there was some abuse back then and as a result the government said okay let's go ahead and help industry mature. Typically I believe it and on services businesses you do that through change in the rules, payment rules. Because nobody wants to change and so the money changes until the rules change. So in the HME industry there were many changes that took place that helped the industry mature. If you look at that industry today there are fewer players. There's certainly still fragmentation but there are fewer players and several large dominant players. In fact a big transaction took place yesterday for AdaptHealth Care. So that is matured. If you look at the home health industry, same thing happened. Forever it was cost reimbursed. There wasn't even a question about – the word "profit" didn't exist in home health until the rules changed. And it went from cost reimbursed to perspective payment back in the year 2000 and there was another major change in home health just about a year ago that PDGM was a new payment model introduced into the home health law. So there's a surety that's going on. Hospice is no different, especially given the fact that hospice has now exceeded dollars being expended versus home healthcare. So you've got a point in time where Medicare is spending more money on a death benefit than they are on a curative benefit across the country. So it's obviously gained attention from Congress and from

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	CMS and I think they're looking for continued maturity in the business. I think it's going to take the shape of several different forms by going forward here, so in the near term.
Meg Pekarske	So let's talk about these different forms that you think might take us into the future cause I don't think it's one saying, right, cause I mean you know like one hospice provider in the country but what do you think are those new iterations, like so let's compare and contrast, like what the market did look like and what you think it might look like into the future.
Mark Kulik	Yeah so back to the numbers, to give some perspective, hospice as we tracked our proprietary data since our inception 23 years, there's been kind of a flow of deals, transactions and those transactions are both small and large. You know a small 50 census hospice is one transaction, a large 5,000 census hospice is still one transaction. So we track transactions and it was hovering in the 25 transactions for a year, maybe 3 transactions for year at the early part of this last decade. But over the last three years there's been a remarkable focus on hospice. So to our numbers in 2018 there was 35 transactions. 2019 there was 48 transactions and then last year all time record 58 transactions in a COVID pandemic. So who knows what that number would have been had there not been COVID present last year. Digging into that last year number though several important factors spring up. Number one if you look at who's buying and who's not buying and who's the for profit and who's the not for profit, I was surprised. So over a same time span if we look at the for profits and not for profits, there was consolidation there. There were five transactions in 2018, 8 transactions in 2019 and 11 transactions, not for profit transactions last year. That was just under 20 percent of all transactions in the marketplace, took place with not for profits. So the pressure that we're talking about for the past couple of minutes both pertaining to the for profit and the not for profit side of our industry. Digging further into that if you take a look at well who else were the buyers in the marketplace, there were both private equity type buyers, financial plan buyers and strategic buyers. So the way that broke down was of the 58 we had 26 were these strategic buyers and 32 were the financial buyers. So a large number of transactions, 55 percent of the marketplace has been sponsored or generated by financial buyers, significantly different than it was years ago. Typically you had relationships between not for profit entities or large regional players or family businesses. Now you have large institutions that have taken a major position in the industry and they're doing most of the buying as well. So a major shift in who's buying, a major shift in why they're buying and certainly the impacts are being felt by both the for profit and the not for profit sides as well.

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Meg Pekarske	And so when you say strategic buyer is that someone that's in the market already and I want to create, like if I own home health here I want to buy a hospice here so I, or I want to extend my footprint to another state or something. It's someone who's already I guess committed to the industry, not a new player.
Mark Kulik	Correct. Yeah exactly right. Their focus, their mission is to provide hospice care services, a marketplace for the future. That's who they are, that's their core focus. A financial owner is jumping in certainly to provide quality services but their timeline is very short. Typically those financial buyers Meg are 4 to 7 years and they'll come in, own a business, help it to grow rapidly, help it to mature. They'll infuse capital to improve technology, financial reporting, quality reporting. They'll bring a talent into the business as well and their goal is to sell it at a much larger size for a much larger price, typically 4 to 7 years later. Exactly right.
Meg Pekarske	When we look at sort of the other side of this data about – cause we just started about who's entering in the market, so who's leaving the market? And so is it all sort of small family owned company? Like who's leaving the market and – cause I think that that's sort of an interesting way to think about it.
Mark Kulik	Yeah and again same thing that change is a foot because there certainly are small hospices that decided to sell. There are 30, 40, 50 census and they're in a nice community. They've done very well but they're not going to grow beyond that. Maybe they're single location, maybe they're two locations but a mom and pop type scenario. I was stricken last year, 2020 by the size of some of these organizations that decided to exit. And when I say exit I mean sell, they haven't left but they've just decided to take themselves out of standalone if you will. So if you look at last year several large transactions, AseraCare Hospice 2,000 plus census was bought by Amedisys. Care Hospice Group was another large provider bought by Private Equity, a TH Lead Partners. Queen City was highly publicized. Queen City was 900 census to 1,000 census, somewhere in there. They were bought by Addus, public company again. St. Croix Hospice, private equity owned but 2,000 census was sold to a larger private equity firm. So you've got one financial buyer selling it to a financial buyer and then Harvard Light Hospice, another large provider 1,000 census or so was sold to Darlington Capital. They own Traditions Health Care and they were sold as well. They were sold by the original founders and sold into private equity owned entity. So you're looking at large, very very large hospice providers deciding that you know what my standalone status is not best for my vision for the future. I'm going to sell out to a bigger entity, be it a public company, be it a larger private equity firm. I don't feel comfortable competing as I currently stand

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	here today. That is remarkable because if you had said 1,000 census hospice five years ago, ten years ago definitely 15 years ago they would have felt impenetrable. They would have felt no I'm very good, I'm comfortable, I'm secure. That feeling, that sentiment has changed especially given the transactions that we saw last year.
Meg Pekarske	And so do you think that I need to be bigger in order to compete, do you think that to be attractive to Medicare Advantage plans, that greater cost savings efficiencies to get more resources? Like what do you think that means when it's – cause obviously size isn't everything but part of it might be. So can you unpack that for me a bit?
Mark Kulik	Yeah you hit upon all those things. In some cases there's more than one reason that generates that decision. So absolutely size is definitely a benefit in the services business like we have. You have certain access to capital. You have certain abilities to attract talent. You have certain experts that can run departments. You know if you're a mom and pop, if you and I owned the hospice together we would cover all the functions and I'm good at a couple of things, not good at everything. And when you get to the large entity, they attract the best of the best and they've got the best individuals that are heading up each respective department as an EDP or a SEP and they bring expertise and they're focused to run that business every single day whereas a mom and pop is typically doing multiple things along with having a family and living a life. So different disciplines are brought to the table. I think certainly reimbursement, the evolution of reimbursement and change is absolutely the stimulant to making a decision to sell at any particular point in time, as well as the market itself. You know one thing we haven't talked about yet was just record valuations. The valuation is – for hospices has been staggering. It brings smiles to the owner hospice. Certainly if you buy a hospice you're thrilled that you've got now a bigger entity to own and to run and you're hoping that that becomes more valuable in the future. But the marketplace has been at all time record highs and you could look to the public company to see their price earning ratios or look to the marketplace to see direct value, even to multiples, all time record high. So if you will their currency to buy right now is pretty cheap. If you're a public company you've got Philly dollars to buy with because your stock price is so valuable. If you're a private equity you've got cheap credit if you consider that the cost of capital and just interest rates. Look at personal mortgages, all time record lows. You can get a mortgage for 2 percent. So these companies are accessing credit for very low costs that allows them to go ahead and offer larger prices to these people to sell, owners to sell when you've got a lower cost of capital. So it's all those issues and more, not to mention who controls the patient or the referrals coming from and you've got different

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	strategies relative to the flow of patients. Because of COVID this year Meg you've got issues over people saying wait a minute, there's maybe not a need to have a step down from a hospital to a skilled nursing facility to the home, maybe go right to the home. And of course with COVID we've seen more cases where the – unfortunately the use of hospital, hospice benefit rather has been very short because the patients have been sick and they've passed within 3, 4, 7, 10 days of being placed on hospice. So all those reasons have brought different powers and different pressures to bear on decisions to sell for any given hospice agency.
Meg Pekarske	So one segment I think is interesting to spend a little time talking about and I don't know that there's a straight line here but is hospitals and their role and the hospice market and you know I feel like it's – the pendulum sort of swings back and forth. I mean there's hospital based hospices. I feel like for a while they were offloading and then you know maybe if CEOs are starting thinking like oh I want to be everything under the same umbrella and then it sort of swings back and you know I think the struggle with hospitals is you know post-acute care isn't usually their core business and it's hard I think, sometimes struggle to be successful at it and even BMRs obviously very different and whatnot. And so what do you see with the need for hospitals to feel like I need a foothold in you know hospice and post-acute care, is there a straight line there or is it just sort of system by system to use it differently?
Mark Kulik	Yeah I think it goes back to the adage that all healthcare is local. I think it comes down to local circumstances, certainly are you rural, you know versus being urban. Are you part of a large national entity, are you more of a regional player, are you community based hospitals? Hospitals have been struggling this past year and I saw a number and I was surprised that are threatening to go out of business this year and who'd thought a hospital would be out of business. But over the years and I go back to my original days, back when the business was the D&E business – everything. I mean they wanted to own floral shops, they have restaurant inside their facility. A couple out in Michigan had valet parking companies that they own. I mean they were trying to diversify. And diagnostic labs and clinics and physician offices. So I think they thought let's own everything, the whole healthcare cycle. And then you're right then the sign curve kind of kicked in and they said no we don't want to do all these things. I think today it's probably a different answer again based upon our local pressures, the marketplace etc. But I think the general feeling is I can't be good at things inside my four walls and be equally as good as things outside my four walls. Very difficult to do. Different circumstances, different management strengths, different reimbursement. Certainly when I see hospitals that own hospices, very rarely do I see one that's being run for profit, you know the hospice is being run for a profit. They typically are being run for a loss and

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	it's not a ding against leadership, it's just the same principles that work inside the four walls don't work outside the four walls. I mean basic of basics different reimbursement number 1. Number 2 you've got a diffused work force. I mean your work force is in their car, they're in the community. They're not inside your four walls. They're not in the cafeteria for lunch. They're not taking a break on the fourth wall. They're out in the field by themselves, you know there's no one else to call in. And then you look at just the economics of it, certainly impossible I seeing that try to provide hospital based benefits, medical benefits, PTO time, adoption services, educational reimbursement, etc., apply that to a home health reimbursement model almost impossible to do. You can't stay competitive on the pay and provide that rich of a level of benefits if you're in the hospice or home health business. And then just even running it. And to just even how you run the business, how you manage the referrals. You get out there and get that referral flow to come to you, you just can't sit back and wait for the phone to ring or for admissions to say we have a new patient, please admit them on floor number 1, right where the admitting department is. So I would say that hospitals I think depending upon who was in charge they have different philosophies but I think it's very difficult to run programs that are not with inside your four walls. So as a result I probably see more hospitals get out of the hospice business and those that want to stay in are doing partnerships. They're looking at saying I don't want to own this whole thing by myself, let me bring in an expert company that can come in and run it for me. So the last big one I saw was Fairview. They brought in Accent Care. And typically what happens is the hospital retains ownership of 10 or 20 percent and 80/90 percent goes over to the experts that know how to run a home health and know how to run a hospice business. So the ones that want to stay in I think are pursuing that model. There's very few that are keeping hospice and not scratching their head as to my gosh how can we get this thing to break even, what do we do.
Meg Pekarske	Sure.
Mark Kulik	So that's what I see right now as the current trend and the current forces being brought upon health systems relative to owning hospices.
Meg Pekarske	Yeah no I think that's really interesting. In my innovator series it was Bill Finn from Hospice of the Western Reserve, he talked about that same thing and using partnerships of hospitals as a way to – it can be a win-win for both parties because you bring an expertise that they don't have and you know is there a way that it can still stay partly under the umbrella and whatnot. So I think and true I think seeing partnership, even if it's not an ownership partnership, if you can do something really wow for someone and you don't have the cost – and especially I mean the value proposition

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	of your losing money at this, this isn't really helping you, you have stagnate growth, you know all this different stuff. I mean I think even if it's you know not ownership, I think there's a way to create a really good value proposition for the health system because I think when you look at all of the disruption that's coming or the optimistic ways, new opportunities to get upstream, all of this is trying to say we're awesome at, you know case management. We're awesome at you know patient care, patient outcomes, meeting patient goals and carrying that forward cause the skills we've developed as an industry are really unique and different and I think you know whether we like it or not it is coming is you know new opportunities to get – you talked about four walls, we're in the six month prognosis you know four walls right. And it's like, but we have a lot of value we can add to other parts of the healthcare system, to patients early on in their disease process. And you know finally we're starting to see shake loose different payment models cause that's always been the challenge with non-hospice palliative care is well but if I'm only going to get paid for a physician visit, a MP visit, you know I'm not going to have the kind of impact that I think can really make a difference in patients' lives and so anyway I think that that relationship of how we connect with the rest of healthcare, that's part of the transformation that I think is coming is getting more integrated even if that's not under one umbrella. It can be through his partnerships and other innovation. But tell me what you see from your perspective on some of the forces that are shaping, both what's going on right now and in the future and the things that I see sort of good and bad we have this aging population that's continuing to grow. We also have MedPAC you know recommending that the cap for overall reimbursement for hospice be further lowered. We have this Medicare Advantage carve in. These reimbursement changes so we had the two-tier reimbursement, they had SIA which is trying to pay hospices more money which I think the government's been scratching their head like I'm not seeing as many – even with this sort of carriage, I'm not seeing as many you know visits in the last seven days of life. And then we have this constant drum beat of enforcement and compliance and competition and these are in like the bucket of – I envision those balls. I don't know if was like the price – the price is right. It's been a long time. But like you know you've got the balls bouncing around and some are eggs and some are really good and so I mean there's an aging population but then all this compliance enforcement sort of drags that down. And so as one who sees how you know buyers may value some of these things, how – cause this is a mixed bag here but you're saying the market is so hot right now what is that? Like how do they see these things that I see as a lawyer?
Mark Kulik	Yeah I was exhausted just listening to you describe all that.

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Meg Pekarske	(*laughing*)
Mark Kulik	Let me take a step backward though before I take a step forward. So back to the money point that you described at the top of your comments there, you know it's pay or schizophrenia because whether you're a hospital or surely in the home health side, you got different rules. You know you got Medicare for service, you got this thing called Medicare Advantage out there, if you're in that part of the business right now or in the carbon program. You got the VA. You got Medicaid in some cases. You got private commercial insurance. You got prior authorizations if that's applicable. You got the schizophrenia. And here you are trying to run your business with different rules and different rates and different levels of requirements and if you're a hospital executive and a hospice executive, you're changing the engine on the plane while it's flying in the air and you got to change engines. And you know then if something is required commitment to change, do I change the engine for one year, for two years. You know if you go back, one example ACOs, I don't know three years ago, four years ago, that was like all the rage. That was the big....
Meg Pekarske	Yeah.
Mark Kulik	...that was the big topic. That was the big change. That was the big expected future and the promise. I haven't heard a ACL acronym I don't think in the last 18 to 24 months.
Meg Pekarske	Yeah.
Mark Kulik	The ACL acronym. So I'm not saying it's over I'm just saying it was kind of the payment du jour and we moved on to something else. So back to your comment, back to your question because I kind of teased that up. I see three really big forces right now that face the industry. But the biggest one I think is Medicare Advantage, you hit the nail on the head. I draw that comment because I watched a parallel industry of home health. It's made a significant difference in the home health industry and typically there's precursors. I see home health as a precursor to hospice. For those that don't know about Medicare Advantage it's run by commercial insurance companies but it's administered by CMS and CMS is trying to get as many beneficiaries, Medicare beneficiaries out of fee for service and moved over to the Medicare Advantage side. So the most recent numbers I've seen are 50 percent of Medicare beneficiaries are now enjoying Medicare Advantage as opposed to traditional fee for service Medicare.
Meg Pekarske	And to that point there was just a survey that came out and it was like, I had to read it twice cause like this can't be true and it was surveys of Medicare Advantage beneficiaries and whether or not they were satisfied with their plan. And it was essentially a 99 percent approval rate. So when

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	you say that 50 percent you know it's just, I think it's going to keep going up and up and you know they can offer supplemental benefits, some things that you might not have covered under traditional par day and they can do that. And so there's some added flexibilities but I was just astounded by that, you know approval rating and so you think the trajectory is going to be, and this is why the carbon is going to be so significant cause 90-95 percent of our revenue comes from Medicare and if now like 70 percent of that is going to be through commercial payor, it's like oh my gosh and then it's not going to be any willing provider, it's going to be okay who has the contract with Medicare Advantage, it's probably going to be a couple of people and you know what matters to that. And that's what I think is, you know as you – I think it's great analogy of just like changing while you're flying because I think that you know there's going to be different things that are valued and it's not just like right now, there could be a patient preference for a provider but it's not going to be like and now we don't get to play. It's going to be like yeah you don't get to play because they're not going to contract with you.
Mark Kulik	Right.
Meg Pekarske	It's a different census. It's like all I have is my 5 percent Medicaid only. Something you know it's just – so I think it's a really you know interesting time.
Mark Kulik	Yeah you were spot on and buckle up here. So let's peel an onion a bit farther. So in the Medicare Advantage world there are four providers, four commercial insurance companies that control 70, currently, 70 percent of all Medicare Advantage dollars. So one is United, one is Humana, one is the Blue Cross Blue Shield group and then the last is Aetna CVS. Those four entities or four associations or groups control 70 percent. So get back to the why are things changing in our world right now. If Humana is a dominant insurer in your marketplace of Medicare Advantage beneficiaries, you've got to figure a way to work with Humana or you got to OI yourself or be bought out by someone that has leverage against Humana, maybe has a large population because you said it perfectly. It's not any one provider, it's going to be two or three providers, maybe give a MSA and oh by the way if your lucky enough to sign up with Medicare Advantage and become one of those approved providers, we're going to ask for you to sign a contract that says and you agree to discount your daily per diem by 15 or 20 percent.
Meg Pekarske	Yeah.
Mark Kulik	That luxury of working with Medicare Advantage and oh by the way almost a 100 percent right now require prior authorization. So you've got to engage that payor first, make sure they're going to pay you, get

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	authorization before you bring the person on service. Kind of sounds simple, it's not that simple especially when you don't get paid, if you don't get that PA number and that reauthorization number. So there's a complexity there that's going to add cost to your back office, getting back to opening comments about getting bigger you have to get more sophisticated and have those experts running those departments to be able to handle that business because if it was the Meg and Mark Hospice Agency, we could work 24 hours to do that. I gave you top billing, I gave you top billing Meg, Meg and Mark. So – or the M&M Agency, maybe that's....
Meg Pekarske	Yeah yeah.
Mark Kulik	But we can't do everything so you have to get to a bigger entity that has the resources and capabilities to deal with – and leverage and negotiating power to deal with those Medicare Advantage plans. So that to me is the biggest fundamental change that's on the near horizon. I think the next one that you touched upon is regulatory oversight. Same thing I used the parallel to home health agencies. It has continued, it's increased in their world and it's kind of dominating now. One quick example is just this pilot program called "Review Choice Demonstration, RCD." It really is prepayment review. You have to go through a prepayment authorization process to get the approval to send your claim in to get paid. That never was the case before but that is showing to save a lot of money to the Medicare program and is showing to weed out a lot of fraud and abuse in the industry. So I think that program is going to continue to grow on the home health side certainly and would not be surprised if some integration of that would appear on the Medicare fee for service side on the hospice world at some point in the near future.
Meg Pekarske	Yeah and I think that's an interesting point cause you know if you're again being like well is a prior authorization helpful to the extent that then I don't have to worry about those post payment audits, right, of second guessing me years and years later and Medicare Advantage plans can still do audits and like this happens on the Medicaid side but Medicaid programs that have prior auth, they get post payment review all the time and it's like well I got those prior auth, you looked at all the medical records and you said it was okay and now someone else is saying this isn't okay and you make this sort of double jeopardy kind of argument and it like well of course it's written in like well it doesn't mean that we – this gives you any sort of insurance policy to the future. And we're certainly like well but isn't that what the prior authorization sort of process is. So I think it's an interesting – in terms of when we think about enforcement, of getting our head around like wow, what is really difficult for hospices is all this post payment review and would somehow that be lessen. You know obviously I can't

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	read the tea leaves but audits can still happen, you know in those managed care contacts so. But yeah so anyway that was number 2, number 2? What's number 3?
Mark Kulik	And one comment there too, just the pressure involved in all that because I think more and more people would like their loved one to be on hospice sooner, be on the hospice sooner and enjoy the benefit longer and those longer lengths of stays right now, the average life of stay is 89 days. That was last year across the country. The median stay was 18 days. So the average is 89, the median is 18 and 28 percent were on service for less than 7 days. So we had a lot of COVID issues. You had a lot of people being discharged from a hospital. They get into hospice for 2 or 3 or 4 days and unfortunately they pass. So certainly people are understanding to get on hospice sooner is better for the patient, better for the family but as you see that happening more and more, that of course is going to raise greater inspection back to your point about let's double check, was this appropriate, was this patient on service for right amount of time, when did they get discharged, when were they admitted, you know are we double paying for something. So a little bit of a double edge sword there where I think there is encouragement to get more patients on to hospice sooner but that's going to invite concurrently more in session accordingly because the dollar's going to grow. So to the third point I think reimbursement pressure. You touched upon that as well. You know hospice has been really fortunate, we've been getting one to two and a half percent increases on average per year. If you look at certainly home medical equipment and absolutely home health agencies, they've been getting cuts each year. So the benefit has been fueled by continuing to improve the reimbursement. But to your point you've got MedPAC has been sitting on the side for years now saying we're paying too much, they're too profitable. So MedPAC this year is saying no increase, you know no soup for you by next year. And oh by the way we want to cut your cap by 20 percent so you can't cap 30 some odd thousand dollar cap it's going to be more like $25,000 cap. And again follow the money, that's a way to manage the business, the managed behavior is to go ahead and make those cuts. So typically CMS Congress ignores what MedPAC says but they have influence. I mean impacted up with U shape curve and we don't have that today but we have a two tier system today. So they do have influence and it may not be direct but they have influence because they're watching, suggesting, influencing behind the scene. So that's the third pressure is that reimbursement pressure and again tied to some of the things we spoke about a few minutes ago. Not to mention other things that are on the horizon. Direct contracting and primary care first and all these other reimbursement programs taking place kind of in the

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	macro environment around us that may have some impact on the hospice industry someday as well.
Meg Pekarske	Mm-hmm yeah and I think that, that's why this is an exciting time as well is you know we've been trying to elbow our way out of the six month prognosis bucket which is in exact, has all these challenges and so you know one of the things that we're talking about in the series is seeing the opportunity for service of versification. So when you talk about you know – because most of our revenues, Medicare fee for service, we don't have these relationships with the Humanas of the world and others. And so if you have a non-hospice palliative care program or you want to model some pilot, something with them, this is a great time to start building those relationships and even if your contract cause it's not carved in right now with hospice, if you had a good experience with you on non-hospice palliative care, other types of things, I think that can go a long way into am I going to be one of the three that they tap. And you know who knows what will be on their short list but you know I mean I think quality does matter and you know geographic footprint matters, prior experience matters I'm sure. You know lots of different things but I think there is just an opportunity, it's not just sitting back and waiting for this stuff to happen. I mean that's obviously my goal here is to get people food for thought and not sort of want to bury their head in the sand but really see opportunities for new stuff to percolate and you know like I said in our description, I don't think it's a one size fits all but if you're not doing strategic planning right now and thinking about how am I going to look different, who are the different people on my team. Like that was one of the reasons when I changed over to Husch Blackwell, I just saw that what my clients needed from me was going to be different into the future and I had to have different skills on my team to continue to be helpful and insightful to my clients and so you know I'm a tiny micro – but I mean it's the same type of thing. Like you maybe need different people on your team than you had before and so I really think you know this is a time to shine because I think that there's a lot of – and it's an overused word but innovation that's possible right now. Because I think payors and outside of just the traditional Medicare contacts are really interested in the skills we have to manage advanced illness and are going to pay us to do that you know and not just NP physician visits but really in a more holistic way and you know I think ultimately have a meaningful impact on the lives of patients. So anyway when you get back to the mission of what we really want to do as an industry I mean I think it's these forces could actually better align us with how we can live our mission. So anyway I'll get off my soap box Mark cause there are....
Mark Kulik	I think you're hitting another core point. You have to embrace the change. Change is going to keep on happening and it's not going to stop and

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	certainly I look at – look at the bigger entities. Kindred bought Gentiva but they thought that marrying up a home health hospice with a facility space was the future. They split apart and sold to Humana to insurance company. Recently you've heard that Encompass is exploring splitting away from, with the Old Health South and splitting away from the facilities. Brookdale the same thing, looking at splitting its home health and hospice from its facilities. You had a pharmacy buying an insurance company. CVS bought Aetna. Change is going to happen and it's a disruption and you have to look at how you embrace that. What do you do with that, how do you take advantage of that. And so this past year with COVID, look at all the change. And I think there's going to be some permanent differences coming forward because some things that people said we can't do that, you know face to face, has to be face to face. Well you saw how that didn't play out per se. And how last regulations took place, I haven't heard any bad stories come out of COVID, I've heard all positive stories. People are really setting up, the industries responded marvelously, everyone has been pulling for every single patient. So I think we're going to see some relaxing of some rules that were untouchable before because of what happened because it forced us to change. So you're spot on in my opinion.
Meg Pekarske	Well and I think that in terms incidentally to I think the role of technology and to the future and I don't want to see a healthcare environment that you know the human touch doesn't matter, you know but I do think and we've explored this on other podcasts like Michael McHale on his innovator series was talking about how you know, how you are using technology. So if someone calls and needs a visit you know exactly where your staff is and you can get someone there very quickly and that you have better triage and you know they built a triage center. And you know I think what you can do with phone support and you know analytics in terms of understanding when do people need you as opposed to well this is when we can come see you. I mean it becomes much more consumer friendly and so I think you're right that the role of technology and the lessens that we learned, you know telehealth I think is here to stay even though that's one of those things I was like oh we can't do that and you know we're going to have to test it for 800 years before we could ever you know trust that there could be a value here. So which I think you know we say that sort of tongue in cheek but I mean I agree that it's, this has been a great disrupter but look at what we learned.
Mark Kulik	Yeah.
Meg Pekarske	And look at what we got to places faster than we ever thought we could and so I agree that there's some bright spots there but – and so as we sort of bring this to conclusion here, I just wanted to sort of if you could share your thoughts on – when you look at what MedPAC has been saying over

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	the years and what the government's concerns have been, I mean do you think the market is responding to that and do you think like the hospice industry is headed to where the government wants it to be or you know where do you think we are, where do you think the government is leading us and do you think we're following their instruction or what's happening here?
Mark Kulik	Yeah I would say in the MAC role yeah we are responding to how the government is leading us. Certainly the Centers for Medicare Medicaid Innovation that can model Affordable Care Act has come up with a whole bunch of pilot programs and different ideas and suggestions and I think the industry has tried to come up with ways to present data that supports the value of home health and hospice to those providers. That's still evolving, that's still happening on a major level. But I would say going back to the transitions, you're seeing the industry respond. They're saying I've got to get larger, depending upon the payor source that's going to be in place when the time comes, I've got to get more sophisticated, I've got to get – use technology more. Data, I need to have better use of data. There's something out there called predicted analytics that are trying to predict you know when is the right time to move a patient sooner from home health to hospice. What's the most effective point to do that. So there's other things that are going on that technology is going to be needed to be able to provide factual decisions but I see the industry and the larger players are definitely embracing those different types of technologies and they're embracing the future. They're embracing at risk payments, that they want to go at risk. They see that as an opportunity to differentiate themselves. You know again when I first started it was all about who had the best smile. I mean everyone said we had the best – our phones are all open an extra hour on Fridays and I can come by in service you. But that was all the things that kind of made a difference. They still have there place today but I would say today it's empirical data, who's got the better data, who can prove that you're the best. Who can show that – in fact talking about interaction of performance and penalties, hospital don't want to see the same patient come back in their hospital in 30 days, that's a penalty in the home health side. So I got to prove to you if you're the hospital administrator that I can keep your patients safely at home. Patient satisfaction scores are highest in the community. My quality is highest and I've got the lowest on the expected ER visit rates back to your entity. That's the partnership that the more sophisticated payors and partners are going to want to see. So having access to the data, managing it properly, being able to present it, that's part of your value proposition today, much more so than if it's Tuesday I'm bringing by the jelly doughnuts, you know that's my normal piece to take 25 years ago. That's all changed dramatically so.

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Meg Pekarske	Well and I think that what sticks sort of I think we're never going to get away from and I think is – can get increasingly appreciated is just the role of compliance and the value of that.
Mark Kulik	Yeah.
Meg Pekarske	And you know you're not going to win the day by paying kickbacks or you know whatever it may be. I mean it's proving through data that I'm caring for the right people, I'm doing a good job and yeah you can't hide behind the smiling face that's like well show me. And they're going to keep expanding hospice compare and you know now they're going to put survey data on there and so there's going to be just more and more data where you're going to get compared to yourself. And I think greater transparency in that data too cause right now it's like okay you tell me this but I don't know how that looks from the rest of the industry and so I think that like you said it's being able to prove your value. And I think you know to leave on a high note here, I think that the hospice industry is better positioned than I think really anyone else to lead this change because we are so good with having difficult conversations with patients and really deeply listening about what are the goals of care instead of doing what may be is financially or you know what I think is good for you. Like let me ask you what's important to you and what are your goals and being able to have those conversations early on in the process so people's healthcare is aligning with those goals. Which every time I say this it just sounds like common sense but it is really true that that is a unique skill that I don't know if we as an industry take for granted cause it's so part and parcel to who we are but it is really unique skill that – developed and I think we can really quantify the value of that because satisfaction's going to be higher and often times if people feel like they have a choice of well what's important to you, you can align their healthcare which may be I don't want as much healthcare or you know whatever it may be, who know what people necessarily want but so often it's not what is it that you want, it's like I will do what you – what my protocol says I should do as opposed to what is your goal as a patient. And so I think we have a great story to tell and can really make a difference in healthcare and people can see us as bigger than a hospice who's – just dealing with end of life cause I think all of the skills we have are really super valuable. So we'll see but clearly other people see that value and now it's just telling people with a megaphone that we are your people and we've always been able to manage to a budget and what other provider has a cap and overall reimbursement. And all these sort of constraints that we had but still provide excellent care. So I think when you start unpacking it we're actually really well positioned to do all of these things that I think you know Mark you've identified and so but exciting time nonetheless. So we'll have to have you back in 2021 cause yeah the amount of activity in the market it's like are you thinking this is going to

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	be even greater record year?
Mark Kulik	I think so. I think we're going to see more consolidation, I mean more transactions this year and I believe that this year will become the new record versus the 2020 record that was established.
Meg Pekarske	Yeah well and my guess is at some point it will slow down but you know for right now I think that as people are you know figuring out where all this is going I think we're going to continue to see that activity. So well this has been a delightful conversation and I really appreciate your time Mark and your experience and perspective I think is really helpful to our listeners. So thanks for making the time for us.
Mark Kulik	Well my pleasure, thank you for the invitation.
Meg Pekarske	Well that's it for today's episode of Hospice Insights, the Law and Beyond. Thank you for joining the conversation. To subscribe to our podcast visit our website at huschblackwell.com or sign up wherever you get podcasts. Until next time may the wind be at your back.