Transcript: Private Equity, AI, and the Future of End-of-Life Care | Part Two

Welcome And Part Two Setup

Jeff Haffner 0:01
Welcome to TCN Talks and Anatomy of Leadership. We continue the conversation in part two of Private Equity, AI, and the Future of End-of-Life Care. And now, here's Chris Comeaux and Cordt Kassner.

VITAS Core Values And Mission

Chris Comeaux 0:20
Well, as we go into this next segment, I'm just gonna cover my final ones very quickly and hand it to you. So kudos, because hopefully my some of my for-profit friends will want when they call me to complain about some of the things in part one, they'll maybe give me kudos in this one. But it was a hospice news, the VTOS CEO, new CEO, Joel Worley, for core values of hospice care. And Lord, I think that was a high click on article. And you know, I think probably I'm not dissing VTOS, but usually core values and VTOS are not the first thing that people think of. It was a great article, actually, and the values were really well stated, and love that he actually put that out there. I think that bodes well for VTOS's future as long as there's aren't words on a piece of paper. But it felt heartfelt, actually. It felt very profound. And any good organization calling people back to the foundation and the mission is a good thing. Um last few things.

Cordt Kassner 1:12
Just jump in real quick that I would I would just slightly push back on you that that when I think of Vitas, I do think of core values, and this did not surprise me a bit. I thought this was a well-stated article and and well received. It was one of the uh higher clicked on articles that we've had. So kudos to them for what they're doing.

Fixing US Healthcare Before Bankruptcy

Chris Comeaux 1:33
Good Pushback. And then um, this was a healthcare article, Don Berwick, one of my favorites, talking about from lagger to leader, why healthcare in the United States is failing

and how to fix it. So here's just one quick excerpt. To achieve these goals, we recommend these changes to ensure coverage for all, which actually was one of our podcasts last year, um, which was the uh oh gosh, I can't believe I'm spacing on the guy's name, but it was the prescription. He went and studied all the healthcare systems, PRE. He went and res researched all the healthcare systems all over the world. So coverage for all, invest in primary care and social determinants of health, create financing to incentivize population health, improve transparency, which was what we talked about a couple moments, price transparency, and accountability. And so major systemic transformation of the U.S. healthcare system is not just required, it's a moral and economic imperative. One of my predictions is it's gonna come to a head this year economically, and and the the red lights on the dashboard of why the current system is not working, whether we do something or not, it's still the crapshoot. And when you and I did the show in January, we weren't in a war in the Middle East, which we now are, and there's in some of the hiring data, we really healthcare was really still kind of fueling the economy. Now there's some mixed signals there amid some broader economic challenges brought on by the war. So it really is a crapshoot about the the signs are gonna come to a head. Do we do something about it? You got the midterm. So I'm just calling that out. I don't know how it's gonna play out. But if we don't pick health care, we go bankrupt in the Medicare system by 2033. So it's gonna be the only opportunity. It's kind of like road is out up ahead, major sign. Do you just keep going or do you do something about it? That's kind of my prediction of where we're headed this year. Not saying the road is out this year, but it's out at some point in time in the very near future if we don't pick up.

Cordt Kassner 3:26
You know, the only thing I chime in with this one is uh I have often said if Joan Tino writes it, I'm gonna read it. And I and Joan's coming up on a on a future podcast, which I'm really excited about. The only challenge I'd throw out there for you, Chris, is I say the same about Berwick. If Don Berwick writes it, I read it. Yep. Let's get him on the podcast.

Private Equity In Hospice Debate

Chris Comeaux 3:49
Oh, that's a that's going on the to-do list, man. That is going on the to-do list, and we actually have a team member who knows him well. So thank you for that recommendation. All right, last one, and I'm handing it to you. How private equity is ruining hospice care in the United States. This got me thinking. So I am obviously very pro-nonprofit, got me thinking instead of just dissing on private equity, we did a past show. Um, Laura Cath Olson wrote a book called Ethically Challenged. But if you step back, what is the role of private equity? And here's a cool analogy. So private equity,

really, the role is to buy companies, to try to improve them and sell them later for more money. There is a contemplated exit to extract value. Nonprofits, there is no contemplated equity. You have a compact with the community to care for people. At end of life, I think that's a core differentiator. And I think that um in your report core to the top 50, I think it was slightly down the number of of the top, I think of the top ten, five were kind of PE owned in the past. I think it was six. So one kind of dropped. So hopefully that's maybe a good trend. But I think private equity coming into the hospice space because they need to crank out outcomes. Now so then the hypothesis is hospice is a space where you could generate large outsized return because that's what PE is looking for. It's not looking for a normal return, it's looking for outsized return. Here's an analogy that I found. Imagine buying a house. You renovate it, you improve it, you increase the value, you sell it. The bad version of that is you take out a huge loan, cut corners on repairs, try to flip it quickly, even if the house isn't better. Unfortunately, in hospice, most of the examples, PE back, it's more of the ladder. It's not part of the form. Now, whether that changes going forward or not, we'll see. But I'm just calling it out. Me, the data really supports more of the ladder, and I've got lots of anecdotal examples. We've interviewed people, work for private equity, um, maybe trying to recruit them in some of the hospices we work with. I've got a perfect example. The guys like, and we were cranking like 30% margins, and they called and said we want 12% more. 70% of those costs are staffing costs. Where is it gonna come from? People by the bedside, getting back to your example in your in your family court. So I thought this was a good article. I don't think private equity has a good space in healthcare because healthcare is perverse. The more you do good for people, you should make more margin. And that is the core problem. Private equity needs to go to other places to create outsized returns.

Cordt Kassner 6:23

I and I think what you're describing is what a lot of people are very concerned about with the entrance of private equity into not just healthcare, but hospice in particular. My pushback is and and you said it in in your comments, the evidence you have is anecdotal. And I the reason I'm I'm pushing on that button is because I'm involved in a couple of research studies that are trying to answer the question based on data. Does it does private equity ownership make a difference? And we're actually seeing based on quality data, it does not, that it is not based on private equity or a for-profit, nonprofit. There are other factors at play that are driving some of that. There are egregious examples, no doubt about it. But is that characteristic of the entire field? And right now, I would say we don't know. And so we're looking, and I would encourage listeners to take all of those questions and add more questions to the pot, and let's go explore before we throw any provider group under the bus. Let's actually figure it out first. And so the good news is that those projects are underway. Like we're looking. That ties into that hospice uh news

article on the 50 largest chains. Well, we need to identify who the chains are so that we can look at outcome measures. And that's what we're doing now.

Chris Comeaux 8:04
Or you take it over.

Oregon Cracks Down On Bad Actors

Cordt Kassner 8:06
So when I took a look at the articles over the last three months, there were a few that that really popped out for me. Uh and Chris, great, great articles that you were reviewing uh in the first half of the show. I'm using Ira's uh framework in particular for identifying articles. And so he's Ira (Byock) starts off with zero tolerance for waste, fraud, and abuse. And uh over this month and characteristic of the last three months, we've covered about 15 regulatory and enforcement stories a month, underscoring how fraud continues to erode public trust and threaten the hospice benefits long-term viability. So it was so we start off with that side of the coin that we need to eliminate that. One of the stories that had almost 4,000 clicks on it was Oregon's legislature passed the Protecting the Dying Act, Senate Bill 1575, which requires background checks for hospice owners, sets minimum qualifications for administrators and medical directors, and bars individuals with histories of healthcare fraud and abuse from owning or operating a hospice in the state. Importantly, it also imposes a temporary pause on issuing any new hospice licenses until the Oregon Health Authority, their Department of Health, can update its rules with these enhanced protections. This bipartisan effort, led by Senator Deb Patterson and supported by leaders such as Barb Hansen and the Oregon Hospice and Palliative Care Association, sends a very clear message. Ethical, patient-centered providers are welcome. Bad actors are not. I mean, very specifically, so that what happened in California doesn't happen in their state. I hope your I you know, I hope all of our listeners states are engaging in similar work. Know that someone, Oregon, has paved the way.

Chris Comeaux 10:18
Man, Ford, our good friend Arabia. I was thinking about this the other day, and I hope you can send this podcast to him. Um, I'm a huge history buff. This is our 250th anniversary this year as a country. Many people call the soul of the revolution with Samuel Adams. He's not just a beer guy. Samuel Adams was the spirit behind the revolution, and and and many people called him a firebrand. That's our Dr. Bayak. Getting all over, oh, you know, he's gotten pot shots about the framework. Now the term collegiality into criminality is resulting in bills like high five, Dr. Bayak. Whatever, you know, whatever negative feedback you've gotten, kudos to you being the spirit of this revolution of making sure end of life

care thrives into the future, the whole serious illness movement. I just want to give you a high five. I think because you've given us a good term, it should. Collegiality should end the criminality. There should be bills like this in every 50 states. I mean, the most vulnerable people of our population, and oh, by the way, you've heard me say before, Arnold Coinbee, who's studied every civilization that he's a man, the number one indicator if they continue as a civilization is what did they do for the old and the firm who couldn't do for themselves. This is a no-brainer.

MedPAC Signals Payment Reform Ahead

Cordt Kassner 11:33
Right and left should come together for bills like and on a personal note, Ira and I co-presented together. He invited me to join him in a workshop at AAHBM a couple of weeks ago. One of the highlights of my career. I mean, he's such an amazing man. It was such an honor to share the stage with him and even you know, continue learning from him as we're sitting next to each other presenting this paper. So as we get into uh his four calls to action, building on the momentum of integrity, uh, these aren't abstract ideals, they're practical levers for distinguishing good care from truly excellent care, fostering transparency, rewarding quality, and reclaiming our authentic brand. So I picked one article in each of these buckets to discuss today. Under clinical and programmatic standards, how do we move beyond good enough to consistently excellent compassionate care? One of our most read stories this month, 13,000 reads. I think it's the second most read story we've run in the newsletter ever, uh, was MedPAC's March 2026 report to Congress. This influential annual summary pulls no punches. Key highlights for me anyway, included for fiscal year 2027, MedPAC recommends eliminating the planned updates to the 2026 Medicare-based payment rate. That usually takes everybody's breath away. They have recommended it regularly, and that rarely happens. But let's continue with that. While it may feel controversial for nonprofit hospices, which in their report make up 16% of providers today, and averaged a negative 1.3% margin, but this reflects the broader fiscal realities. For-profit hospices, now making up 82% of the sector, averaged a robust 13.7% margin. And MedPAC is long flagged. Margins above 10% is raising fiduciary concerns in a publicly funded program. The second point that I'd highlight here in 2024, more than 1.8 million Medicare beneficiaries, including over half of all decedents, received hospice services from roughly 6,700 providers, with total Medicare expenditures reaching $28.3 billion. So we're almost at 30. Well, we are at $30 billion when you include non-Medicare expenditures. The share of decedents using hospices hit a new high at 52.9% in 2024, up from 51.7% the prior year. I consistently beat the drum around hospice utilization. And this is the highest hospice utilization we've had on record. So that's that's exciting. Some implications. Payment policy must balance access, quality,

and stewardship. This is all we were talking about in the articles that you were reviewing, Chris. This balance between money and services provided. Some hospices have unique challenges, like rural providers and those specializing with pediatrics or dementia. And those deserved nuanced considerations in reform. One hospice is not the same as the next hospice. And we've got to, in my opinion, look out for our rural providers, look out for our hospices doing really unique work. This report invites us to reflect are our clinical standards rigorous enough to justify public investment, regardless of ownership model.

Chris Comeaux 15:33

Well, I'm just going to point out what I think is obvious. Uh 13.7% margin in the for-profits, negative 1.3%, not reflective of competency. It's reflective of where we put our dollars. Now I'm not going to defend every nonprofit. I I get to work with a subset. I would love the opportunity to work with all of them one day. Um I we are helping these programs become high performance and they're putting care by the best side. I love your call out earlier when you were vulnerable in part one about your personal experience. Maybe we've been the victim of good is good and you know, good to great was all about has has good become the enemy of great. I'm all about let's become great. This data shows that there's a difference in the model. Just maybe interesting thing for you to follow up on court. Look at who provides the four levels of care. Now crisis care, continuous care is very difficult. At least look at those other three inpatient respite and routine home care. You get a lot of homogeneity and those for profits. And you see some very long-length of state because they target then the nursing homes, get more non-cancer diagnosis, et cetera, which produces great margins. So they even cherry pick some in the patients. And that's some of the, again, anecdotal. I don't go all over the country. We do work in at least 14 states throughout the country. That's what we see, and that's what produces the difference in the margin. How they target the population, homogeneity, versus routine home care, mostly in nursing homes and facilities, longer length of state patients, a lot easier to care for, and they have less staff because they can spread that staff over more and more patients, produces greater margin. Whereas the programs I work with, large acute population, you know, a lot lot more high acuity, a lot more diverse throughout the whole community. Yes, do they serve facilities? You bet, because that's actually part of the community, but they don't niche just at that. And they have a lot more people by the bedside. Now, I know some nonprofits have a lot of people by the bedside, and and they're average, they're mediocre. They're not getting those visits in the last seven days of life, and they should improve.

Cordt Kassner 17:31

And I think Medicare is is holding hospices across the country more accountable for the for exactly the measures you're talking about. They're looking at those, they're slicing and

dicing, uh segmentating the hospice market in different ways to make sure that services are being adequately provided in each community.

Chris Comeaux 17:53
And one more thing, you and I bumped into in the past, that you know, the percentage of hospices that actually participate in the actual satisfaction surveys, we got to remove. I mean, what is it what oh just two-thirds zone or 50%, whatever the number is, it's ridiculous, whatever it is.

Transparency Through Hospice Data Reports

Cordt Kassner 18:10
Yeah, absolutely. Next, transparency through meaningful accessible data, evidence, not anecdotes, should drive decisions. Our second most read story, uh, with over 6,100 reads this month, features the National Alliance for Care at Homes 2025 Facts and Figures report, an indispensable annual resource that details patient characteristics, care settings, uh, and levels of care, Medicare spending, provider profiles, and quality metrics. It draws on several sources. Hospice analytics contributed to several of their uh charts and graphs with data, uh, but uh a fantastic must-read report uh that uh just really summarizes hospice nationally. Again, it helps us figure out where an individual provider fits into the bigger picture of hospice and healthcare.

Chris Comeaux 19:03
Yeah, and I just want to give props to you, the fact that you guys are you know, I could hear a lot of leaders, I don't have time to read the daily newsletter, I don't have time to read this facts and figures report. I'm sorry, guys, this is well, first off, this is why we do this podcast, is to pull out the things you should be focusing on. We got to get more sophisticated as we go forward. And yes, mission is beautiful, but if you can't back it up with data, um we may then it may be on us that we lose this incredible thing that we actually created that is called Hospital today. And so, whatever excuses you give, we got to get more sophisticated how we look at that data. What does it mean for your local market? Most importantly, what does it mean for how you're then leading your organization to focus on what matters most for the people by the bedside and challenging your organization to be the best person?

Pediatric Care That Lifts The Field

Cordt Kassner 19:51

Absolutely. Ira's third pillar, driving competition based on quality, not volume. This shifts market dynamics towards outcomes that truly matter to patients and families. A heartening example. The HAP Foundation in Chicago released its pediatric resource guide, a comprehensive collection of supports, financial, transportation, emotional, and more for children with serious illness and their families. I just want to congratulate the HAP team for their work on this. It's a great uh resource that folks need to be aware of. Related, the Alliance is hosting an upcoming webinar series we're gonna highlight in the newsletter soon on pediatric concurrent care, featuring experts, Drs. Lisa Lindley and Megan Weaver, uh, both fantastic colleagues and experts, expert researchers and clinicians in in this area. These resources highlight an underserved area where specialized knowledge can dramatically improve experiences.

Chris Comeaux 21:03

But they use pediatrics as a market differentiator for their whole hospice program. Now, to be honest with you, I thought that's cool, but I was always kind of skeptical of the implications until recently. Got involved in a very interesting payer conversation and we're at the table with some amazing people on the payer side, uh, one of which that grew up on the pediatric side, and we were kind of doing the Vulcan mind meld between crowdcare competencies and kind of their perspective. And I had this huge aha listening to this brilliant person about pediatric pediatric by nature look to the patient and family as the true center of care. Like, think about it. You're not gonna just look at the pediatric patient, you've got to look at the whole family support. And they were saying this is why they love hospice and powder care because that's so innate to who we who we are. And that's relates to a lot of other pediatric and it's just spawned this incredibly uh innovative brainstorming of just some really cool. best practice ideas from the pediatric side that I think we can improve from which then harken me back to the theory of this one hospice that their pediatrics would actually elevate the clinical practice of their whole organization. So the fact that we've got I'm seeing more programs that come back to pediatrics. You know, it is hard to make the model work financially. Not impossible. It can actually work. Um maybe even more so compared to palliative care just in general because other funding that's out there for pediatric care. So just want to high five you for pointing that one out. And I think there's a whole frontier of pediatrics that could actually elevate and love the term rising tide raises all boats might be an interesting strategy. Not only is it the right thing to do from a mission standpoint, it may have implications you didn't even anticipate on your overall hospice out of care quality care.

Bucket List Programs And Authentic Brand

Cordt Kassner 22:50

You know, I would just echo that with a personal story that I hadn't thought about this until you were talking about it. But years ago I I had the opportunity to co-chair the University of Colorado Hospital Ethics Committee and most of the ethics consults were end of life. They were geriatric end of life. So I my interests in hospice and palliative care you know fit very nicely into a lot of the discussions we were having. Well my co-chair was a neonatologist and she brought end of life perspectives from the beginning of life. And it really complemented the conversations and added breadth and depth to the services that we were providing for the geriatric end of life. And so in that same sense what you're describing is uh those those nuances and and the care that gets provided for pediatrics can really enrich in our geriatric services. Well well said finally and perhaps most powerfully embracing and promoting our authentic brand the compassion dignity and meaning at hospice's heart these stories often travel farthest because they remind us of why we do this work. This month Friends of hospice in Oswego County New York in partnership with Hospice of Central New York in the Finger Lakes and Hospice of Jefferson County launched its lifelongings bucket list program. So I'll pause there to note Friends of Hospice is not a hospice. They're working with hospices to do different programs including this bucket list program. This particular initiative provides non-medical support to individuals facing life limiting diagnoses, fulfill meaningful wishes, whether that's a special meal, a family gathering or a simple comfort upgrade this is what hospices do all the time they this helps us, I believe, reclaim hospices original spirit, not just managing symptoms, but honoring lives and legacies in this era of regulatory pressure and financial scrutiny these kinds of initiatives counterbalance the data and dollars with the humanity behind why we do what we do. They build community trust and staff morale authentic branding isn't just marketing fluff. It's a strategic antidote to burnout and cynicism how's your team listeners all listeners how's your team incorporating similar life affirming elements and and getting back to that authentic brand of hospice that's a beautiful part and I feel like don't say anything Chris don't screw that up because that's the mic drop moment and the best way to end this podcast.

Chris Comeaux 25:48

But it does remind me of one of our store our stories we had expanded our hospice into um a market a region that had not been well served death service ratios were less than 30% and um we started kind of that kind of what's their wishes kind of program and beautiful story. One is a gentleman he was a retired Baptist preacher he had a vision of going on an RV trip with his family and of course he couldn't do that because he was terminally ill but our team got together got an R V and he was able to go to an R V just like a a what do you want to sort of like a a park an R V park locally and his whole family joined him and he baptized his grandson in the pool at R V and it just created memory and actually several years ago bumped into one of the family members and shared just how impactful that was. It wasn't about the pain and symptom management we did. It

was that life affirming thing that now the family is carrying forward and now that young man's following in his grandfather's footsteps going to become a preacher himself and it's just such a cool full circle moment. And so high five that you pointed that out um why I kind of keep the my first category but I find I'm flagging less and less that whole mission life affirming kind of thing.

Send Your Best Hospice Stories

Cordt Kassner 27:03
Well and in that regard I would encourage all our listeners that if you have similar stories just write them up. Put them put them you know get permission write them up put them on your webpage and send me a link to it so that we can run those stories in the newsletter and share them across the country and and hopefully get that that flywheel spinning faster and faster because I think there are some examples out there. It's a matter of if we know about them or not. Please help us draw our attention to those stories and those examples it could be in your hospice you know quarterly newsletter that you highlight a story and you put your newsletter on your webpage send me a link to it we'll we would love to include more of those stories.

Wrap Up, Subscribe, And Brain Bookmark

Chris Comeaux 27:53
Amen because that should be getting the headlines not oh my God can you believe there are a hundred hospices or license in the same location suite on the same day that's horrible and it's painting all of us in a bad light whereas oh we're so busy we don't have time well guys it's kind of up to us it's what we bring to the forefront. So thank you Court for this was fun. Any final words no it's just a thank you for taking time and and uh allowing uh allowing me allowing us to to discuss these topics and share it with your listeners and I I think this is how we change the world amen absolutely so you and I in the next couple months we've got uh Tom Casumphtis and Carol Fisher from MPHI joining us after that we got Joan Tino coming up and then after that it'll just be you and I again and we'll keep kind of rolling this way each quarter where we'll bring some out some outside guests again using Dr. Biock framework and then Court and I will look back over the quarter keep calling out pointing out top news stories of the month. So thank you again Court you and Joy keep doing the great work that you're doing for our listeners we appreciate you. The end of each episode we share a quota visual we're going for a brain bookmark like a brain tattoo I'm looking forward to seeing this one for this show it's gonna be fun. Be sure to subscribe to our channel we don't want you to miss an episode

make sure you also tell your coworkers your friends um this is one I'm gonna kind of uh tag several people because there's so much good stuff in this easy for us to rail against the world and be frustrated by things just be the change we wish to see in the world.

Jeff Haffner 29:26

So thanks for listening to our podcast and here's our Brain Bookmark closed today show "The people who are crazy enough to think they can change the world are the ones who do." by Steve Jobs. Thank you USI for sponsoring this podcast.