Value Based Strategy Partner: Build or Acquire

Bill Kauffman:

Okay folks. Welcome to the session. I think we're going to jump in, get started here if you can take some seats. Thank you all very much for attending this session today. And good afternoon to all, with our Value-Based Strategy: Partner, Acquire, or Build? We're going to get into a lot of good discussions today, a lot of good detail. I think we have a fantastic panel. So we're looking forward to provide a lot education, some value to you as you take the time to attend the session today.

Bill Kauffman:

And just a little housekeeping, a slide was up there before, but there's a survey on the chair. You can actually fill that out on the chair or it will also be emailed out as well. We'd love to get the feedback, get some good feedback from you to see what you think about the session, et cetera. So thank you for that. And as we get started here, I think just to give you a quick overview of what we're going to do today, we're going to talk a little bit about vertical integration and really a lot about vertical integration. And what we're going to do is do a pretty good detail intro with all the panels.

Bill Kauffman:

We have three panelists here obviously. Phil Fogg from Marquis Companies, Lynne Katzmann from Juniper Communities and Peter Longo from Cantex. And each of them will give a nice detail of what they're up to these days, give some intro on themselves and their companies. And then we're going to get into some overview of this slide that we had today. But what we would love to do after that is get some good Q&A with the audience. So what I would ask from you is as we're going through some of this initial discussion, if you can think about more detail of what you might want to hear about, what might make sense to you or does not make sense to you, please, no dumb questions. We want to get some good discussion with the audience today and go from there.

Bill Kauffman:

That said, if we can jump in a little bit. So we put together this slide and really I think we got it from Phil here. This wheel basically showing a lot of the service lines. And you can see if you kind of look from the left middle there, started with hospice, go all the way around hospice, home health, assisted living, all the way around to care coordination. So really that's kind of what we're going to be talking about today from a vertical integration standpoint. And we have a lot of experience up here on the panel as far as this goes and jump into that conversation.

Bill Kauffman:

But what we would like to do also is just gauge the audience a little bit and we're going to poll, just kind of get a feel for where you are. If there's some operators even on the owner operator side, we'd love to know where you are at all on that. So from a polling perspective, we want to get into our first question here. There's just two questions. And just real quick before that, of course there's a QR scan code on the back of that card or you can also text. As you can see at the top of this slide, you can text NIC to 22333 either one for this polling. So we'll get a minute here for you to do that.

Bill Kauffman:

But the first question we want to dive into is, are you already vertically integrated into two or more lines of related business? So if we can just take a minute to do that either with a text or the QR code and we'll wait a few seconds for that. And the reason it says 100% is because we tested it before and I responded A. So there's only one respondent so far.

Lynne Katzmann:

One more person came in.

Bill Kauffman:

Yes, there we go. We're ramping up. We have a few seconds. All right, so it sounds like some people were in the right room then. So we have about over 80% as far as being two or more lines of related business. So that's good news. That's good to hear. So we can understand what the audience wants to talk about a little bit today. And this next one, if you take a look at that and you'll see it within the app, there's actually a bunch of different options. It's not just the five that you see up here. It's going to score the top five. So if you're already vertically integrated, which are the following are you currently engaged in? We're going to take another few seconds to jump into that and we'll see what the top five is here.

Bill Kauffman:

It seems the initial top five might be the top five. Another few seconds. So skilled nursing, memory care, assisted living, independent living and home health. And certainly we can hit on all of that. But as you'll see when the panel engages, there are certainly certain ones that they've been engaged with and more experienced with. So we're looking forward to hearing that. And I think to get us started off, we will pass it to Phil Fogg to get into some detailed intros.

Phil Fogg:

Thank you. My name is Phil Fogg. I am president and CEO of Marquis Companies. We're headquartered in Portland, Oregon. I founded the company in 1989, which means we just hit our 30 year anniversary. I have to tell you, a lot of the discussions that we'll be having today are going to seem like we were brilliant strategists. We started an effort to diversify into new business lines and integrate more as a survival method. You may not know this, but Oregon was one of the worst reimbursement states in the nation in the 90s. Today, it's one of the better. But it was because it was such a poor economic situation that we had to find new ways of creating earnings just to survive.

Phil Fogg:

But when the affordable care act hit in 2010, it suddenly made sense for us to be able to organize around these business units and to be able to manage the post-acute care episodes in populations. And we'll go a little bit further into that. Our organization is really organized into three different divisions. The first is Marquis, which is basically a long-term care and post-acute care service provider. We have facilities in three Western states. We also do home health care with both private duty and Medicare. And for the lenders in the audience, we do own most of our real estate, 22 out of our 25 communities, we own the properties.

Phil Fogg:

The second division is called AgeRight. And we refer to that as our care management or risk management division. And that is comprised first of all of a Medicare advantage ISNP plan. We partnered with Ally Align in 2017. I can't remember, I think we were one of the earlier adopters, certainly not the first, but one of the earlier providers to do that. When we started the ISNP, we made a decision to employ our own NPs and physicians. And so the second business unit there is our clinical services.

Phil Fogg:

And then finally this year because of huge managed care penetration and a very tough negotiating environment, we created a post acute care network where several providers came together and we tried to change how we negotiate and how we define our contracts with plans. Mostly we focus on a lot of the non-economic. We use a messenger model for the economic side so that we don't get into antitrust issues. The third business unit is what we call our business to business division. It's comprised of rehab, we have contracts all across the United States.

Phil Fogg:

Our pharmacy serves 28 to 30,000 seniors in the Western United States with four pharmacy locations. And then in 2012, we started a data analytics solution, which today has about 700 facilities on it. May not seem like a lot, but I'm pretty sure it's got the most facilities that are submitting real livetime data of any solution that's in the marketplace today. So that's a little bit about us. I'll hand it off.

Peter Longo:

I guess I am next. Thank you. So I'm Peter Longo. I'm a managing partner of Cantex continuing care network. We are a private company based in Dallas, Texas. We've been in business since 1978. We began as a skilled nursing provider but over the years have vertically integrated and today I'll tell you a little bit about our story from that point of view. I'll echo one thing that Phil said was that there were motivators at each step of our vertical integration path and our story. And essentially we've created, at this point we have six lines of business. There are really three major stages as we vertically integrated over the years. The first is really motivated by PPS in the 90s.

Peter Longo:

And like everybody else, as we were trying to figure out how we were going to pay for the ancillary services that were embedded within our Medicare part A rate, we pretty quickly decided that we needed to have our own pharmacy. And that was the first move that we took in the mid to late 90s, by creating PharmaCare. We currently have three pharmacies spread out over the Texas market. And then not too long after that and in the similar time frame, we brought all of our therapy in house.

Peter Longo:

We tried to have three different outside providers so we could kind of hold them accountable one tothe other. But we ultimately decided that the best way to deliver the best quality care to our patients as well as control costs was to have our own therapy service, and we did that. In both cases, we've kept both of these businesses completely in house. So unlike Phil, we haven't gone out to the market, although that remains an option. So PPS is really the first driver that stimulated us to vertically integrate in those two steps.

Peter Longo:

Then in the mid-naughts we began to see as we were growing our inpatient portfolio and building new buildings, we could just see how many patients we were referring to other settings and questioning ourselves about why are we losing that referral flow. And not only are we losing the referral flow, but we're losing the opportunity for a seamless hand off to another setting. And we could see that there were clearly synergies between inpatient services in a skilled nursing setting and home and community based services.

Peter Longo:

So we decided first to create a hospice company and we chose to do that de novo so that was sort of its own experience and that was sort of a particular kind of vertical integration experience that was quite labor intensive and slow although capital light. And then we decided that we wanted to be in the home health business and we thought long and hard and thought we're going to acquire this time so we can get scale more quickly. So that was much more capital intensive but we quickly scaled up on the home health side.

Peter Longo:

Our goal was not to acquire these segments, just sort of scattershot in different locations. We've always been very focused on geographic clustering for efficiency and we think a platform that is better positioned to achieve good outcomes. And similarly, as we added these business lines, we said they need to follow and be very much geographically in sync with our inpatient facilities. So both our home health and hospice divisions are very closely tied geographically to our facilities. In fact, I'll show in the next slide that 95% of our SNFs are served by our home health services at this point and 75% of our SNFs are served by our hospice services. And that was very intentional on our part.

Peter Longo:

And then finally in the teens, just in the last few years, as we've transitioned from volume care to value care, that was really the stimulator for yet another growth spurt or vertical integration, a sequence of moves, if you will. And we were behind Phil and Marquis Care. But we've now launched in 2020 ISNP under the brand of ProCare and we also have worked with Ally Align in that and Amy and the team at Ally Align. And in conjunction with that, we like Marquis, also created our own nurse practitioner and physician practice which supports our ISNP and that's called NP ProCare.

Peter Longo:

And on the horizon for us at least in terms of what we're thinking strategically is there's probably another set of related steps after this. We're certainly very interested in the institutional equivalent SNP to serveice patients that are in assisted living, in independent living. We're interested in a Medicaid managed care plan, a DSNP likely, that might be something like ProCare Plus for us so that we can actually actively enter the Medicaid managed care market. So those would be additional lines that we're currently thinking about.

Peter Longo:

So key themes for us as we thought about diversifying and entering vertically integrating. We were primarily interested beyond these specific motivators, PPS and referral opportunities and value based care, those are sort of situational. But the key underlying conceptual themes for us were diversifying risk, both regulatory and reimbursement risk. Now, we're a Texas provider and we've certainly seen the bumps in the road in terms of a very difficult reimbursement state. And like every provider we've seen regulatory uncertainty and we felt that having these different business lines would mitigate risk for us on both the regulatory and the reimbursement side.

Peter Longo:

And we also felt like these were natural business extensions, that we were literally harvesting opportunities that were in our laps we were referring to these other segments. And we said to ourselves, "Why are we referring to someone else when we could be in that business line?" And that was a very important motivator for us. We did have guardrails in each step. So our guardrails

stayed geographically concentrated. That had been a very big focus for us over the years as we built our portfolio. And by getting into new business lines, we wanted to be sure we didn't start to straggle in an inefficient way, geographically.

Peter Longo:

And we didn't want to take on outside business until we had thoroughly proved internally our product. So we do still plan on taking some of these ancillary services out to other providers that might want to partner with us. But we thought it was important to hone our skills, settle our product, get our sea legs, if you will, before we went outside. The outcomes for us, it's we ourselves remain somewhat amazed. We hadn't really thought it would go as quickly as it has, but today 30% of our patients are in the home and community based services side. So that is very sort of surprising to us given that 15 years ago we didn't have any home health or hospice patients.

Peter Longo:

And our goal would be ultimately to be equally penetrated in our markets on the home health and hospice service side as we are on the inpatient side. And when you look at the math on that, for every nursing home inpatient, there are four or five home health patients in your market. So really to be fully penetrated equally with our skilled nursing business, we would have four or five times as many home-health patients. So today we've got between 12 and 1300 home health and hospice patients versus 3000 inpatients. And there is plenty of runway for growth to get equally penetrated in those markets.

Peter Longo:

But even though 30% of our patients are in home and community based services that reimburse at a lower rate from a revenue perspective, fully one third of our net income comes from those services. So this was an outcome that really helped us achieve the goal, which was to diversify our margin and make sure that we were getting margins from different businesses. And we have managed to prove out in our model that those businesses, home health and hospice are equally as contributive at the net net level.

Peter Longo:

So after you take into account that we have capital costs on our inpatient facilities that we don't have on our home and community based services facilities, when you look at that net net bottom line of the skilled nursing facilities after they pay, we own all of our buildings outright so after we pay any interest on debt that we have, they are very competitive businesses, one with the other and they offset their risk one with the other. And I'll also mention that pharmacy, as we enter a world where many of us are considering taking on risk through ISNPs, it's a lucrative business and it's one that really amps your game in terms of being able to serve your patient population and actually provide all the elements of care in a very coordinated way.

Peter Longo:

That as well generates more than a third of our bottom line comes from our pharmacy business. Even though that's a totally internal business for us, we don't have any outside customers. Challenges, and I'll finish up with just the challenges that I would say from our experience so far. Management bandwidth. I think we all face that, we certainly at each point where we were expanding. You can't be in a crisis and expand at the same time. And I think for many of us in these industries, as we go from periods where we're facing big challenges right now, whether it's the Coronavirus or something else, it's hard to undertake these major... they zap a lot of attention and you have to find the right moment to do it and

have the people in place sometimes giving yourself a little bit more bandwidth than you might otherwise need in order to explore other business opportunities.

Peter Longo:

The other thing I would caution from our experience is that financing. So, many of us who began in senior housing or skilled nursing, we're used to real estate based businesses that are financed in a pretty straightforward way that lenders are used to. When you start getting into these other business lines, they are cashflow based businesses. There's no real estate involved, so there's not hard assets to borrow against. So you have to sort of learn to have a different conversation and talk to different kinds of lenders.

Peter Longo:

And you may not be able to borrow as much to support these businesses. You're going to need internal cashflow to support them as well because cashflow based businesses don't have that borrowing capacity that a real estate based business would. And then finally on the valuation front, to the extent that you're building an extension of your core business and a new business line, but you're thinking maybe one day I'm going to want to monetize or I'm going to want to attract in outside equity capital.

Peter Longo:

We all need to be mindful that these businesses value differently than your traditional skilled nursing, assisted living, memory care, independent living and that in the marketplace, and we saw this when Kindred was sort of dismembered, if you will and different pieces went to different players, that different businesses don't always get fully valued if they're sold or valued together as the whole. So if you're a senior living company or a skilled nursing company and you have home health hospice, pharmacy, and some of these other businesses, at the moment that you're trying to attract equity capital, you've got to be conscious about being very good at telling the story about what the value is for each of those components.

Peter Longo:

Or if you're selling your business, you probably want to sell those pieces to different buyers because if you sell to one buyer, they're going to discount the pieces that they don't know very much about and because they don't know about them, they're not going to give them their full value. So that's something to be as you think about building your business through new business lines, that their values and the way they're calculated are different that could somewhat complicate a monetizing your business or even raising equity for it. That's the big picture. Lynne?

Lynne Katzmann:

Thank you. Hi. I'm Lynne Katzmann and I've been with Juniper since its founding in 1988. Got a year on you Phil, but you're much bigger than we are.

Phil Fogg:

You're old.

Lynne Katzmann:

Yeah, I'm old. True, true, true. So Juniper today, we've done a lot of different things. I would consider Juniper more of an enterprise strategy right now. When I started Juniper, we were very different. We were looking at buying buildings and we didn't even operate them at the time. Today we operate a variety of different businesses and the strategic thinking behind that has changed fairly dramatically. So today in terms of the buildings, the real estate side, we own and operate 22 communities. And in contrast to my colleagues up here, we are largely on the senior housing side. So we have a predominant number of assisted living, independent living, memory care communities and only two skilled nursing communities.

Lynne Katzmann:

So I think we're in some ways very different in terms of what our real estate looks like in the base of our operating business. Juniper's always been mission-driven and that's been extremely important to us. We have always wanted to innovate. We've always felt that we wanted to do a good job for our residents, but also for our industry and for society. And that's been a driving force for the company for many years and it really informed some of the strategic moves that we've made.

Lynne Katzmann:

Over the last several years, much like my partners here, my colleagues, we created and implemented a new care model, which I didn't know I was to call a care model until two years ago, Amy, I think. And Amy is a colleague of many of ours from Ally Align who has taught us a lot about the ISNP world, which I'll get into in a minute. But when the ACA came into being in 2010, there were a number of things we thought. I bet you, like me, many of you were worried at the time all about the cost as an employer. How were we going to foot the bill for this new individual mandate?

Lynne Katzmann:

And we didn't really pay attention to, at least I didn’t, to the changes were embedded in the act that would affect operations. And the biggest one, the one that I always point to is hospital readmission penalties. And those went into effect, I believe in October of 2012 and they affected hospitals. We didn't think of them as affecting us, but in fact they really did. Because what hospital readmission penalties does is they said to make money, hospitals, you need to make sure that you can coordinate what you do with everybody outside of the hospital. So it was no longer important just to take care of someone when they were in the hospital and then forget what happened to them when they left, but now if you were going to make money, you had to make sure that you were coordinated with the pre and the post pieces.

Lynne Katzmann:

In other words, what happened before and what happens after. That was a really big thing and it really affected how post acute care, our world, now had to interact with the rest of the healthcare system where we used to think of ourselves as silos, we now became part of something bigger. I will say, and I probably have a chip on my shoulder about this, senior housing still is fighting to be considered part of that care continuum and I think we will take our place at that big table in the next couple of years in a major way.

Lynne Katzmann:

But we were never considered part of that continuum because we weren't funded by public sources. We didn't have Medicaid or Medicare dollars for the most part, I realize that's a generalization, but we don't have Medicare numbers. Some of us have Medicaid numbers, but for the most part, we can't get paid

directly by Medicare. That will be important at the end of the story. Anyway, as after the ACA came about, they said, "Well, how do you make sure that you can make money? You have to do this thing called care transitions."

Lynne Katzmann:

What's care transitions? Well, it's transitioning between settings, but nobody's really thought about that before. So what did the government say you have to do? Well, you have to assess people, you have to develop a care plan. You have to monitor them. And when they leave your setting, you have to be mindful about what happens when they come back or where they're going. And I don't know about the rest of you, but that's what we've always done. And so it became clear that this care transitions thing was something that was meaningful and that we in senior housing in the extended continuum did that very well.

Lynne Katzmann:

And so we at Juniper put together a care transitions program. That program was the base for a program many of you have heard about called Connect4Life. Connect4Life is an integrated care program which manages care transitions but does something more. It brings together a host of ancillary service companies, some of which we own, the majority of which we don't. We've created partnerships and joint ventures to put together those pieces of the puzzle in contrast again, to my colleagues here for the most part.

Lynne Katzmann:

So Connect4Life is an integrated care model that brings together a host of companies to integrate along a continuum, a vertical continuum and we use those services across the horizontal continuum, which is essentially our different product types. So at Juniper, we did all that. Now, once we did Connect4Life, we realized we'd created some value. But darn it, we weren't getting that value. That value was accruing to Medicare. We didn't have a Medicare number, we didn't have a way of capturing that value.

Lynne Katzmann:

And after doing a lot of research and getting to understand the world in which we lived in, we realized that the only way we could begin to capture that value was to be part of a commercial insurance program, Medicare advantage. And so Juniper has a Connect4Life program which is an integrated care model that includes a couple of vertically integrated pieces that we own, the care coordination piece and a primary care piece. We contract or partner with others for the other pieces, pharmacy, rehab, et cetera, home care, hospice, along that continuum. So we have a slightly different model than my colleagues here.

Lynne Katzmann:

To create that value, we, like my colleagues here, are now engaging in an ISNP. And that's a special needs plan. We are behind these guys. These guys are the experts, they've been doing it, they've been doing it successfully. We are going live in January of next year. In contrast to my partners, at least as they started, we at Juniper are really small and we were not geographically smart about that. So Juniper's all over the place. And there's a reason for that because originally we didn't operate our own portfolio and didn't have a strategy, a vertical integration.

Lynne Katzmann:

We function more like a private real estate investment trust with a series of partnerships and we evolved into what we are today. So we're not geographically concentrated and that meant that we couldn't do our own ISNP without getting together with others. So our ISNP is going to be started in two states. There are 10 companies, 10 operating partners that will be a part of it in Ohio and Colorado. Ally Align is our third party administrator and our consulting experts in how to get this done, similar to my colleagues here. And those are the two big pieces that I think have shaped Juniper in the last several years.

Lynne Katzmann:

So we have developed an integrated care model with a variety of different ancillary service businesses and I won't spend time today telling you how we integrate that, that's another story. And then we've wrapped around a Medicare advantage program and ISNP to hopefully capture the value that we've created. We've done it with partners which has its own set of challenges and opportunities and we're looking forward to helping shape the industry's ability to show our value to others.

Lynne Katzmann:

And when I say the industry, I mean not only the skilled side, which has been doing it for some time, but also the senior housing side who again, as I mentioned, is not part of the traditional care continuum. So Juniper's strategic goals. We fell into this in 2010 and when we did our last strategic plan, which was 2013 and 14, we didn't really get what our role was going to look like in 2020 frankly. We did think that we were going to have to add ancillary service businesses and we chose to do primary care at that time. We were doing care transitions at that time, but we really didn't think about wrapping it all up together. That wasn't part of the strategy.

Lynne Katzmann:

In fact, our strategy was to create and protect when necessary our enterprise value. So we're more opportunistic. I like to think we're strategic. I like to think we are thought leaders. But frankly I think what we're best at is understanding what's happening in our environment and taking action that is hopefully opportunistic and positive for our enterprise value. We've chosen to grow our enterprise both from organic and new sources, both in terms of the real estate side and also the service line side. Our development of new service lines that integrate have enabled us to grow market share as well as new sources of revenue and total revenue growth. And that's important.

Lynne Katzmann:

So it's not just the size of the market, but it's from new sources. And I think both Peter and Phil spoke to that. There's a need to protect your business in the SNF side. I think the writing was on the wall a little bit earlier than on the private pay senior housing side. But frankly we can't do things the way we did them in the past and so we need to look at expanding our work to be more general. I think that's enough for me. I think we can move on.

Bill Kauffman:

I think we're good. Thank you all very much for that detailed intro. And I think now Phil's going to run through some of the strategic overview and some integration strategies and then Lynne is going to run through some of the capitalization discussion and some decision criteria around that and Peter's going to talk a little bit about due diligence. So Phil, over to you.

Phil Fogg:

Thank you. So we really have three broad goals when we talk about our integration strategy. The first is that we want to protect or increase our market share and obviously very critical. If you win the market share and you win the workforce wars, you're going to win. And so it's really key to us and we build all of our strategies around that building sustainable revenue models, whether it's Medicaid, Medicare, managed care, second key. And then the third is what we talked about earlier, which is just the diversification of risk. Now here we're talking about value based stuff.

Phil Fogg:

So when we talk about that, our quantifiable objectives are really around all the pay for performance measures, hospital readmissions, five-star customer experience, satisfaction, functional outcomes. And we measure those in a very disciplined manner. We meet consistently and I'll talk about our team in a bit. But we're very disciplined in the routine and constant self assessment. The other thing that we do when we talk about value based is talk about what is the cost or value to the payers that we serve. And we really generate that again, on the hospital readmission.

Phil Fogg:

This year we had our first risk based contract that pegged a hospital readmission number. For our post acute care population, we share half of the savings, the hospital readmissions are valued at 13, 5 of readmission. And so if we're below a number, then we share the gain, and if we're above it, then we share in the cost. ED visits, and then member experience is obviously very critical and then the MA plan metrics. Now, I just want to touch upon that because one of the advantages of getting into the ISNP world is you are a Medicare advantage plan.

Phil Fogg:

And so whereas in the past we didn't quite understand why Medicare advantage plans said what they said or perceived things the way that they did, now that you are in this service, you get a lot different perspective and now some of the things irritate you. Like they get their money in the first of the month and so all of the MA plans that don't pay for 90 or 120 or 12 months and they're getting their money very fast. But what you begin to understand is that they've got HITA scores and they've got financial objectives around needing to make sure you capture the health risk scores of the members in your plan.

Phil Fogg:

And so if you could start to tailor your messages to those MA plans, I think you're going to be a lot more effective partner and demonstrate the value a lot better. When we talk about these strategies, there's really several components that I think are critical. Mission and purpose sometimes when you talk about it, it sounds like a platitude. I spent years trying to find a unifying mission or purpose. How many people have read Being Mortal? If you haven't read it, I highly recommend it.

Phil Fogg:

And it was interesting that this book, I read it and if you haven't, Atul Gawande is the author. And it talks about how medical technology has affected the way that we live and age and die in America. And it hasn't just been for the positive. So he shows you a graph at the beginning where he talks about the year 1900, if you were a farmer out in your field, you're 55 years old, you've lived a great quality of life and you have a heart attack and you die. No aging decline, right? But medical technology is now, we save people. And so we save them but we don't come quite back up to where we were before. We live

for a little while longer. We have another incident of some kind or decline, and that slide is what we call an aging decline.

Phil Fogg:

And when I read that, it made me think about some of the advertising that you see in our profession. I love to see the assisted living facilities that have people running marathons in their pictures. That's not who we're serving. We're serving a population of people in assisted and in our nursing facilities who are in aging decline. They've got four to six chronic diseases, they need support. And when we realize that, or when we were able to come to terms with that, what we also realized is, look, we take care of...

Phil Fogg:

We figure in our company we touch about 50000 journeys a year. Individuals who have their own life journey and are in aging decline. And so we thought about that for a little bit and then we realized, look, we care for these folks. Some of them have five years, some of them have five months to live, some of them have five days and some of them have five hours. And in each of those moments, we have the opportunity to support the people we serve. And what we have built our mission and purpose around is helping people live the best rest of their life.

Phil Fogg:

And in that effort, in that endeavor, our team, our champions, so we call them champions of the journey. And when we came to this, it was like the biggest aha moment I think I've ever had. Because what we did is for the first time, whether it was a farm tech in the pharmacy or a pharmacist or a nurse or a housekeeper or laundry person, a home health aid, whatever it was and I can tie this to accounting people, finance people. Everybody in our organization is focused on how do we help people live the best rest of their life. And so that was a big deal to us. And it also informs, and then you refer to this, but informs what we do. What do we own?

Phil Fogg:

Well, we try to control things that are impactful into the people we serve's experience and our ability to help them live the best rest of their life. If it's not impactful, we don't do it. If it is, if it's very important, then we do do it. We engage in it. And so it's driven a lot of our strategies. Lynne talked about care models and clinical workflows and they're absolutely critical now. We think about them in terms of transitions of care. But the ability to integrate goes across further than just transitions. It's management information systems, it's communication. There's just a ton of things, leadership.

Phil Fogg:

So I don't know for sure, but I think the one thing we have done pretty good is we've gotten these disparate divisions with a number of services, we've gotten these leaders to all work together. One of the ways that I do it is I'm religious about keeping them all in the same physical location because I think people that eat together, that talk together, they solve problems faster, they resolve issues faster, they collaborate better. And I see a number of organizations that they've got business units over here, business units over there. And so I think it's one of the secret sauces. But if you're going to deploy an integration strategy, you got to be really intentional about how you get your leadership team to work.

Phil Fogg:

Financial contracts and incentives, same thing. You got to do things that are in the best interests of all of your business units. Now having said that, look, some of our payers and some of the contracts that we have, there's situational decisions and you've got to be able to make those, you've got to be able to do it in a timely manner. Sometimes pharmacy is a profit center, other times pharmacy may become a cost center. If I'm in a risk based contract, pharmacy may be a cost center. Or maybe we've got the ISNP.

Phil Fogg:

Here's a good practical example, is we own the ISNP, we're fulfilling the prescriptions. If it's a high cost drug, you better believe that the executive director of the plan is going to the pharmacy leader and saying, "Hey, I need a little love here. Give me a discount on this drug." And it happens, and it happens almost every day for us. Data. I know everybody's now embracing data and business intelligence. Once again, I think one of our secret sauces has been that every single one of our business units, the operating platform, the operating systems are all integrated into our business intelligence solutions. It gives us tremendous insights into the people that we serve, the drivers of quality, the drivers of cost, and it's been a great investment for us.

Phil Fogg:

And then I already went over the objectives but I think it's critical that all of the services, if you're going to deploy an integration strategy, you got to have everybody working towards the exact same objectives. And yeah, the business units will have some of their own strategies and their own objectives. But by and large, organizationally, you got to know what you're trying to accomplish. And those were the pay for performance and value metrics that I talked about. When I saw the term, vertical integration, it's a little bit hard for me to kind of just talk about it because I don't know that it's really vertical integration.

Phil Fogg:

If you look at the traditional definition of vertical integration, usually you're talking about a manufacturing process and the decisions to integrate up or down that chain or do you get into one of the input businesses to the product? Or do you go and buy at a distribution side after it leaves the manufacturing facility? In our world, it's different. I just wanted to briefly show you kind of the way we look at this. And this slide unfortunately didn't quite come out the way that they wanted to. That lovely lady there is my grandmother.

Phil Fogg:

When we look at what we do, we talk about it in terms of two populations. There's a post acute care population which drives moving people from the hospital to the transition to the facility. And that includes liaisons that are at their bedside in the hospital supporting the transition. We have our own transportation services. It's been a great deal for us. Not only do we start the relationship with the person right there at the hospital door, but we find we can manage the discharge times better because a lot of the reasons that we get four or five admissions right at 4:00 or 5:00 o'clock is either the physician’s not signing the discharge orders right or there's transportation issues.

Phil Fogg:

And so we really were able to even out the flow of our admissions during the day with that. When they come to the post acute care facilities, our clinical services immediately engages the physician, sees them right on day one, pharmacy's doing an admission medication review, and I'm hoping my dream one day

is to be able to get medication reviews done before they step foot in the building so we don't waste 30% of the drugs that we have to DC and prescribe new drugs and rehab is engaged. When they discharge out of that post acute care environment, they could go stay in the nursing facility, they could go into an assisted living, they could go back into the community.

Phil Fogg:

And this is just depicting that we continue to manage them, but that moves more into a long-term living or what we'd call a population management service. And that's where ISNP comes in. The ISNP for me has been the fulfillment of a dream. That's one of those decisions that has changed our organization forever. And I love the service and it enables us to take control of the lives, us to take the risk, us to get the benefit. Yep, we have the risk of a loss but we get to make the decisions. We get to decide where we put resources and how we do that and we get to do it in a way that is functional and thinks about the entire post acute care setting.

Phil Fogg:

So we're also doing meds to home now out of our pharmacy. So we're using longterm care pharmacy serving the discharge medications. And again, all of that's over a data analytics solution. I only throw this up because those are the logos, those are the brands but I think the pictures are more helpful.

Bill Kauffman:

So Lynne, do you want to hit on the decision criteria for the capitalization and talk about the capitalization for integration?

Lynne Katzmann:

Sure.

Bill Kauffman:

And then Peter, due diligence for a few minutes. And I think we want to save about 15 minutes for Q&A.

Lynne Katzmann:

In other words, be fast.

Bill Kauffman:

There you go.

Lynne Katzmann:

Okay. I can do it.

Bill Kauffman:

All right.

Lynne Katzmann:

So these criteria you see are very similar to what Phil was just talking about. There are many ways of building a vertically integrated or a network of services. You can own it yourself, you can build it and

own it, or you can partner or joint venture with someone. At Juniper, we own some of it and we partner. And for us the decision criteria on which structure to use is based frankly on control and cash and scale. So I'm not going to go into each of those, but I will just simply say that if you don't own all the pieces, if there isn't just one leader involved and it's great to work with other leaders because you learn a lot from them, but having to make decisions with other leaders can be very hard.

Lynne Katzmann:

And so if you are partnering with people, your organizations tend to have slightly different goals no matter how mission aligned you seem to be. And that means that you have to have C-suite alignment. You've all got to be working, as Phil said, in common goals. There's got to be real buy-in, not just they say it but not do it. You got to have the talk and the do. Culture is about collaboration, no longer competition. You got to sign on to that. Phil talked about integrated workflows, really key.

Lynne Katzmann:

You can't have individual workflows and expect an integrated network to work. This is not about silos, this is about working together. And working together is different than just saying we work together, you actually have to do it and they have to flow from one to the other. So let's go on to capitalization. So how do you make the decision to partner, acquire or build? How much capital is needed for each and what are the potential sources of capital? So to form a partnership generally does not require a lot of new capital. You both come to the table. One typically offers market, the other offers services and you put together something that hopefully works for both parties.

Lynne Katzmann:

Building a business permits you to share some core services among your different business units. It's the second most cost intensive piece. You have potentially new infrastructure costs for technology or equipment, you've got to have cash for inventory. You've got to be able to cover new management and the associated costs related to that. You've got to have cash to cover your ramp up. So it does take money when you're building a new business, your partner is not in partnership. The other party that has that expertise brings an existing business to the table. And typically some of these other features are not as necessary. So if you're short on cash, partnership makes a lot of sense.

Lynne Katzmann:

In terms of buying an acquisition, it's typically thought to be the most expensive option and because existing businesses, they do command a premium, but sometimes it's the cheapest alternative because you don't have all the other associated costs. So while on the surface it's expensive, it may not be. Now, where do you get that money? In a partnership again, you're not using very much. So typically you can look to internal operating cashflow. You can assume that if one's providing the market and one's providing a necessary service, there's enough in that for both parties

Lynne Katzmann:

And you can generally afford to cover that from what exists already. You're not looking for new sources. If you're going to build something, well, you're building it. You're building your own enterprise value. So you can go to your existing investors, you can use operating cashflow if some exists. You can recap or sell some of your existing assets or of course, you can go out and raise new capital. So there are a lot of options for building. And obviously if you go back to the old control and cash piece, pretty good option.

Lynne Katzmann:

Now in buying, where do you get the money for that? That typically requires new money. You can either lever your existing assets. So raise debt based on real estate if you have it and if it has excess value, or you can raise new capital. And you can raise capital either for the enterprise as a whole. So then you're putting your other businesses more or less on the line, or you can raise capital for a distinct business line. So that's kind of the rubric.

Lynne Katzmann:

And as you go through and think about how you want to do this, assuming that that's what you are looking to do, you have to think in terms of am I ready to partner, do I want to control more? How much cash do I have? And then that filters through to the decision making process. And then when you're looking for capital, there are a variety of different ways to go about doing it. So for the sake of time, I'm going to pass the baton.

Phil Fogg:

Thank you.

Peter Longo:

*Great. So I'm going to spend a few minutes talking about the due diligence process and just sort of assessing opportunities and making a decision to take a vertical integration move or extension of your business lines move. Before I get into that in detail, I do want to respond to something that Lynne said because she talks about not being at the big table. So I think many of you probably know Lynne and she's been at the big table for a long time now. And is certainly a thought leader in our industry and has been very successful in the way that she has vertically integrated and taken on some unique challenges in terms of being willing to broach the uncertainties of bringing multiple providers into one enterprise.

Lynne Katzmann:

That's very kind of you.

Peter Longo:

And we have spoken about that at some length together. So I wanted to say that and I also wanted to say that to Phil's point about mission, very important point and I'm glad you brought it up. Because I think certainly for our three organizations, and I suspect for many of you out there that there isn't always a certain amount of dollars and cents in this about why you're taking these moves. But for many of us, they're multi-generational businesses.

Peter Longo:

These are missions and it's really about providing the most seamless, harmonious group of services that will really be the ones that we want for our families, our loved ones, and by extension into the communities that we serve. So they're driven by dollar and cents, but they're, for most of us, very mission oriented as well in terms of getting to the best outcomes. So I can't emphasize that enough on behalf of all of us. So on the due diligence process, of course, because you're taking on a new business and for many and most cases it's something that is a big learning curve.

Peter Longo:

The first bit of advice that I would give is to canvas your peers. And I think that this is another place where this panel is a very comfortable panel for us because I would say in the sequence of using ISNP as an example, Phil was first, we were second and Lynne is third. And one of the things that was most instrumental to us in reaching a decision to begin an ISNP, which was a big decision, was the generosity of our peer providers, of being willing to sit with us and talk us through their experience.

Peter Longo:

So Phil certainly and his brother Steve Fogg did that with us and gave unlimited amounts of time to answer as many questions as we had to ask and we had a lot to ask. And we spoke to probably five other plans at some length to really just gather information and try to get a sense of what people felt like after they'd made the decision. Was it a good decision? What was working? If they could do something differently from the beginning, what would that be? And our entire senior team was involved in that process.

Peter Longo:

And it not only gave us confidence to make the decision that we made, but we have used so many of those ideas along the way and we feel like we've gotten a headstart in that business, but really in all of our businesses that we did the same thing that that initial due diligence of canvassing your peers or others who have already tread that road before you can be an invaluable first step in the process. Second bit of advice is to make use of subject matter expert. So for us, the first big vertical integration move was pharmacy back in the mid nineties.

Peter Longo:

We brought in an institutional pharmacy provider to be our partner. You probably get the sense both from me and maybe a little bit from Phil. I think our companies are a lot alike about somewhat control oriented. So we like to have control over the pieces-

Lynne Katzmann:

Don't leave me out of that.

Peter Longo:

... of the puzzle. Lynne's gut is fearless. So she will do it both ways.

Lynne Katzmann:

No, no, no, no, no.

Peter Longo:

But we brought in an outside expert but we did not give them equity even though that was their preference, was to take a piece of our pharmacy and sort of travel with us down the road. Our preference was to compensate them in a way that worked for them, but to make them a subject matter expert, to let them play the role for an initial period where they taught us and that where we eventually could get rid of the training wheels and do it on our own. And that worked really well for us in the case of pharmacy. And really in each of the other segments, there was a key person or company or organization that stood with us at the beginning and helped us to learn the business, gave us feedback and critical assessment of what we were doing right and wrong.

Peter Longo:

But then in most cases as you learn, you have the ability to stand on your own. So have a subject matter expert, but give yourself the nimbleness that when you're ready to stand on your own, you can do that and there's no hard feelings. So there's no involvement that may not be something that you need for the long-term. Third, I think this has already been said, but we can't say it enough in terms of researching the regulatory and reimbursement implications. Each of these businesses presents a different risk profile.

Peter Longo:

In many cases, that's going to be a good story for you as you think about another line that will provide you with some protection in the downturn of your primary lines. But you really need to understand that upfront and you don't want to go into a new business line that is about to experience a major reimbursement methodology change at the same time that the one that you're in already is going to do that. So if you were getting into home-health this year, you might've said, let's not do that while I'm adjusting my primary SNF business to PDPM, let me not inherit a PDGM at the same time. You want to watch out for those things and research will help you do that.

Peter Longo:

Assess the synergies. I think as we decided what order and what businesses we were most interested in, it was really driven by what was the natural outgrowth of what our primary core business was. So certainly in the case of pharmacy and rehab, it was like we are trying under in Texas very slim margins to figure out how we can survive financially. And a lot of that turned us to saying we need to bring these things in house so we can cut out the profit margin and the overhead expense of the middleman who's selling us those services.

Peter Longo:

So that synergy really is that as you wring out costs by bringing them in house, you've achieved a synergy. But also, if you're in any kind of inpatient or residential business where you're providing a home or doors, you have natural referral flow that stems from your business. And that is opportunity. And to the extent that you're referring business when someone leaves your setting and let them go somewhere else, it's really not that different than the theme we've heard of the general sessions about at some point, if you don't disrupt and take the business yourself, somebody else is going to take it. And that's a missed opportunity.

Peter Longo:

And that for us has been a very compelling reason at each step of the way is why do we discharge from our skilled nursing facilities to home health or hospice or even assisted living, we now have some assisted living as well, when we can do those things ourselves and let's consider going into those business lines. So you can assess those. As we pro forma-ed our businesses before we got into them, we were able to say, "Look, we've got this many referrals right baked into the pie before we start because they're naturally already coming from our skilled nursing facilities."

Peter Longo:

So that was a process of assessing our synergies and conflicts. When we were getting into home health and hospice, we were conscious of the health systems and the ACOs being a little fussy about were we getting into their business lines and would getting into that business line for us cause us to be a less

attractive referral partner for a hospital system because now we're competing with them in another setting. And I would say even though we thought long and hard and wrung our hands about whether that was going to be a big problem for us, our experience has been mostly all of these players, they're long-term partners of ours. They're adults. They get it.

Peter Longo:

They know why we want to be in the business and that we were able to approach our partners and say, "Look, if you're sending us referrals and you're in home health, then we'll just sort of have an agreement with you that we're going to refer back to your home health if you've referred us a patient. And we're not going to try to steal your business, we're going to be a good business partner. But when we have a patient that's our patient and is not affiliated with you, then we're going to refer to our home health agencies." And we found that our ability to capture referrals on discharges from skilled nursing are about 60% at Cantex in terms of how many home health discharges with home health go to our Cantex home health agencies.

Peter Longo:

And probably we can't push too much further than that because we have a lot of referral relationships with other parties that have their own home health agencies and we intentionally want to be respectful of that. Developing pro formas. It's a business plan. Of course, when you enter a new business, you have to sit down and do the business plan. You have to think forward. I would recommend, we always try to think five years forward. As ridiculous as that sometimes sounds when you're getting into a new business line, but that's where your subject matter expert comes in and can really help you visualize what's going to happen with that business.

Peter Longo:

Not only in the early stages when you're struggling to go cash flow positive or just to get critical mass of that business going, but what it's going to look like when it's really at a stabilized and mature level, how it will contribute and overall integrate with the rest of your business. And then remember, as you pro forma, you're not only pro forma-ing that business, so in the case of the ISNP, as we pro forma-edwhat an ISNP would look like for Cantex, we had the pro forma in front of us, now for five years ahead.

Peter Longo:

You have to then take your other business lines and say, "What will the impact of that new business be on the others? And let's re forecast what our other business lines now look like once they're interacting with the new business line to be added." And in the case of an ISNP, there are tangible other revenue reductions that could occur because you're going to have less, maybe a Medicare part A business, but there's also going to be other advantages financially in terms of gain share that your facilities might make. So those are terms of art.

Peter Longo:

But let me just say that there's a tangible and material impact on our skilled nursing business as a result of having that ISNP. And when we evaluated what was the financial merits of going into the ISNP business, it was critical to take into account the financial impact on our skilled nursing business. And I can remember among the many good nuggets that Phil and Marquis gave us as we were thinking about it, was not to go into the ISNP business because of the financial benefits. Even though they may be there, that there are plenty of reasons that are somewhat mission-driven but related to just the better

way you're going to be able to serve your patients. And I would say we're only very early on in our process, but it's so clear to us, right away we have about 500 enrollees in our ISNP plan.

Peter Longo:

The positive feedback that we're getting from our patients and our families and our facilities about the way that we're able to encompass them and care in a way that we weren't able to before. And having those advanced practitioners in our building every day attending to those patients has been a hugely positive thing. So I think those are the main things that I wanted to cover. And I guess I've gotten us a little bit below the 15. Sorry about that Phil.

Phil Fogg:

I think we're good. So we've talked a lot about integration strategies, capitalization and due diligence. So with the remaining time and a lot of information here today. So from the audience perspective, any questions that you have, anything you want to dig into deeper with all that information? I think we actually have a block that will be passed around for questions coming right now. We've got a question in the back.

Lynne Katzmann:

Who is it? You want to talk? You can talk. [inaudible 01:03:18].

Speaker 5:

Thanks for the speech. Fantastic panel. Really appreciate it. Quick question for you guys is that, I come from the hospital health system world and can you guys hear me? I'm trying to wrap my head around the fact that your overall insured profiles are so small, relatively speaking, relative to typical insurance companies and even health systems that I've seen kind of are integrated with health plans. And a lot of times we tend to think of table stakes being at least a hundred thousand lives. They have a sufficient level of population to diversify that risk.

Speaker 5:

Can you help me just understand a little bit further in terms of what's your average... I mean I'm getting a sense like it's about 2000 or so, maybe 3000 lives that you're covering and I'm trying to wrap my head around, okay, it's a very small pool. So the risk of that bad outcome if you will, obviously you guys are doing it, but you're getting stop loss insurance at reasonable rates to cover that risk. And if you could just talk through that a little bit, that'd be really helpful.

Phil Fogg:

Well, I'll hit it. So first of all, we're getting risk modification scores around 2.4 for the part C side. And that's really key because if you don't get the accurate reflection of the membership that you have and your medical loss ratios go above 85, you got problems. And what I would say is to your point, you're right that when you're smaller in scale, we were at 500, there was increased risk of one or two big losses definitely creating a big problem for the plan. I think most of the plans aiming around a thousand, is that right? Around a thousand is the critical mass that we usually look for. We hope to get there this year. But economically, they don't make a lot of money. It's you got an 85% medical loss ratio requirement, you've got GNAs somewhere between 12%.

Speaker 5:

3% or something like that.

Phil Fogg:

So the opportunity is more on the savings that you can share with the facilities if you can manage your medical loss ratios below 85% and be able to distribute your quality incentive payments or increased fee for service or whatever.

Peter Longo:

If I can add too, because this was a big issue for me when we made our decision and I just couldn't get my arms around how with a small platform it could work. And what I concluded, and obviously we're still in the exploration as we get used to it. And I was informed by what I saw the hospital systems doing because I go to the JP Morgan Healthcare Conference every January and it's a great opportunity to see the big managed care players who are talking about millions of lives and the struggles that they have in some cases. And then to see the hospital systems in Texas like Memorial Hermann or Texas health resources who have sizeable plans but nothing near the scale of the big managed care companies.

Peter Longo:

And they kind of went headlong into the advantage plans and they haven't always had great success with them to be honest. Because they've got beneficiaries, enrollees who are out in the community that they don't really have good control over. And I said, "How are we with a thousand enrollees or less even at the beginning, the risks would be insurmountable," and you wouldn't be able to sort of actuarily spread that risk. And I think that the thing that I was missing and hopefully I was because we sort of got over that was that the ISNP is a very unique situation because those patients reside in our building. They are not in the community. We would never be able to manage patients in the community.

Peter Longo:

So we touch those patients every day in many, many ways and are uniquely able to micromanage a small group of patients. And I think that most of the other peer providers that I spoke to before we went into the business sort of comforted me on that part, is that you're in a totally different world. This is a closed environment. This is not patients out in the community and you're able to manage on a very small scale because of that.

Phil Fogg:

I think you just hit it on the head. It's high, high control. It's funny because the MA plans, the traditional MA plans in our marketplace, they don't have any idea where their members are.

Speaker 5:

I understand.

Phil Fogg:

And I mean they don't know where they're located. When they go into a facility environment, they have no idea unless they've made a pre-auth on a SNF stay. And whereas, to Peter's point, we're on it. I mean, we're on every single hospital admission. We're on trying to divert that hospital admission skill in place. We can manage that risk really effectively.

Speaker 6:
[inaudible 01:08:02].

Phil Fogg:
Yes, we do.

Peter Longo:
Yes sir.

Speaker 7:
[inaudible 01:08:06].

Phil Fogg:
Amy do you know what are the individual in aggregate?

Speaker 8:
[crosstalk 01:08:12].

Phil Fogg:
The agg is dependent upon the plan itself.

Speaker 8:
Yeah. It's $200000 stop loss individual.

Lynne Katzmann:
Can I make a point which is slightly off base to the question that was asked? The fact that we control and we monitor 24/7 365 is really key. The only point I'd really like to make is we create great value in so doing. And one of the reasons I think all of us have elected to participate in the SNP program is so that we can capture some of the value that we create in that. And I think that's an incredibly important point for the industry across the board, across the care continuum or the continuum of products that we have to recognize that we in fact, because we see people in their home on a 24/7 basis and we can monitor, we can identify changing condition and we can intervene very quickly are in a very unique place as compared to other typical insurance providers.

Peter Longo:
And I think in the other sessions we've seen this triangle, the Kaiser triangle and 60% of the determinants being either where home is and social determinants of health. And I think a lot of what you're hearing us say is, we're leveraging. As Anne said, a couple of sessions ago, Anne Tumlinson, that we're unlocking the value from the fact that we have great control over the social determinants of health because these patients in our building and we have a [inaudible]

Phil Fogg:
I can hear Bob.

Peter Longo:

Hard question coming.

Bob:

Each of you are clearly really thoughtful in the way in which you've gone in this and it's just the way you've laid it out, incredibly helpful and really detailed. I guess my question was, despite all the planning, all the consulting with peers, what were the things from each of you that you hadn't anticipated and that surprised you? It might be positively, it might be negatively because I think those lessons might be helpful for those in the room that are considering you've laid out all the steps, what didn't you anticipate? Because in any plan, there's somebody that doesn't go according to plan and you then have to adjust.

Phil Fogg:

I think on the negative side, we've learned over time it takes about three years to do anything well. So you just got to assume no matter how good your five year forecast is or 10 year forecasts are, you're going to make mistakes and you go through a learning curve. And we have a saying, maybe it's my saying, but in our organization we like to be able to say, we suck at this because nothing good happens until we can acknowledge it and just own it and say, "Hey, we're doing this badly. We've got to do better." But I think the negative side was just being able to recognize that it takes a long time to get really proficient at something.

Phil Fogg:

The positive side is this amazing team of people that work together for a common mission and purpose. It's what gets me up every day. And I think that the other thing is we've consumed so much technology. We've done so much innovation, but until 2010, I look back and it was like, I think I was bored from 2006 to 10, because the recession was hit. We didn't really get hit by it. But it was the ACA it was a driving force. It created a number of threats to us. And at the end of the day, it made us be able to transform post acute care. And I think that's what you're hearing from all of us is, this has been a lot of fun, but it has been exhausting at times.

Phil Fogg:

The technology consumption alone has been exhausting. And I just can't reinforce, this is not for everybody. You got to have an organization that's got a lot of capabilities to be able to do. And I'm not saying that we're different or special, it's more people have to be able to honestly assess whether they've got the kind of the intestinal fortitude for it and the energy and the drive.

Lynne Katzmann:

The drive, the passion.

Phil Fogg:

And again, I think that sincere passion for wanting to do things differently, I've kind of got a thing where I'm 55 and I'd like to about in 10 years to be able to look back and say I transformed a little bit how we do post acute care.

Lynne Katzmann:

I totally agree. For me this is a legacy thing. It's hard. It's incredibly rewarding. And I think I'll talk about the bad things in a minute, Bob, but on the positive side, the fact that we can demonstrate the positive value of the work that we all do is incredibly gratifying. Instead of seeing the constant article in the paper that we killed someone or that there was a fire or something negative happened, or alternatively the 100 year birthday party. That's good, that's personal. But at the end of the day, we do so much more.

Lynne Katzmann:

And the opportunity to present a different picture, to show our value and to capture some of that value is what motivates me. Not only personally and for Juniper, but I think for our industry. This is the time, this is our opportunity to show what we can do. It was given to us on a silver platter. It's time for us to show that. On the negative side, it's not easy, whether it's three years or one year, you've got to work with others. Whether you're building the post acute strategy internally, that vertical integration, it only goes so far.

Lynne Katzmann:

You've still got to work with the hospital systems and the other providers and the insurance commissioner in your state. It's not something you do entirely alone. And whenever you're working with others and you're collaborating particularly on something new, it's not easy. So you've got to be willing to say, "Okay. Yeah, I suck at this, or maybe they suck at this and how are we going to fix it and move on?" You've got to be really solution oriented. And I think acknowledging that it's not going to work right every time, the first time, and that there are solutions is really important factor.

Peter Longo:

Just one quick thing. I see we're at a time, but I think that the biggest negative surprise for us was we thought when we entered these new business lines that there wouldn't be silos, that they'd naturally integrate together. And I think this goes to what Phil said, overarching leadership for your organization when you're in multiple different business lines is so important that they all see a common theme that emanates throughout the organization and that you find innovative ways to get them to work together. If you create a home health agency and you're in the SNF business, don't think that your facilities are going to automatically refer to your home health agencies without some education and encouragement to do so. And that was a surprise, I didn't anticipate that.

Bob:

Thank you.

Bill Kauffman:

All right. I think that's a wrap. Thank you audience. Thank you to our panelists.

Lynne Katzmann:

Thank you.