Hospice Insights: The Law and Beyond

Episode 53: Strategic Restructuring for the Future, Think Before You Sign: Five Key Insights for VBID and Managed Care Contracts

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Meg Pekarske Hello and welcome to Hospice Insights: The Law and Beyond, where we connect you to what matters in the ever-changing world of hospice and palliative care. Think Before You Sign: Five Key Insights for VBID and Managed Care Contracts. Private payor contracts will define future revenue for hospices. Whether it be VBID, Medicare Advantage Contracts for Hospice Services or other payor contracts for upstream non-hospice services such as palliative and supportive care, the rules of the road will be defined by what you can negotiate with payors. In this episode, I talk with Andrew Brenton and unpack five takeaways learned in working with hospices on their managed care contracts. We hope you enjoy this conversation, and thanks for listening.

Andrew, we've been wanting to do this for a while, so thanks for making the time. This is an important conversation and it's probably not the last time we'll talk about managed care contracts. So, thanks for being here.

Andrew Brenton Absolutely. Yeah, thanks so much for having me.

Meg Pekarske We structured this podcast in sort of a top five list and whether they're the five most key things. But I think in terms of working with folks through these contracts, there are things that rose to the top of where we saw people either struggling or maybe not being aware or things that perhaps people didn't think about. And that's sort of the origin of these five things. But the very first one doesn't sound very fancy or legalistic. Which is, you need to read your contract and understand what you're doing and agreeing to. So, tell me why that made the list, Andrew?

Andrew Brenton Exactly, I mean it kind of sounds obvious, but a little bit to unpack here. So, and I guess kind of a takeaway here is payor contracts generally are longer, more complicated than many other types of contracts. It probably makes sense to work with counsel on the contract review and the

negotiation process. But kinds of ways in which some of these contracts may be a bit more involved perhaps than providers are used to, is kind of the form in which the contract often takes. So, hospice's other provides often do already have contracts with private payors, and if you're considering entering a managed care arrangement,. often a payor will give you a contract that's in the form of an amendment to the existing kind of base participation agreement which may have been signed by a prior leadership. Staff may not be intimately familiar with those terms, so in reviewing the contract for the managed care arrangement, you will want to make sure that you really understand both terms obviously, but also the terms of the base agreement and kind of how the terms of the amendment and the agreement interact with each other.

Meg Pekarske Exactly. And I think these contracts can be quite old. I mean we've run into contracts where the base agreement is ten years old. And I think where we started the intro here about more of your revenue is going to start going through this contract. So, I really think most people just sign their contracts and never think another thing about it. It's like, we have two patients a year on this contract, it doesn't really matter, right? And now this is going to perhaps govern 60 percent of your revenue; those payment terms really matter in a different way. And so, I think spending time and whether that's working with outside counsel internally, you should not just sign these contracts and even if you don't end up changing anything, you still need to understand sort of the rules of the road as laid out. And just because it's going to be more impactful to your organization, and so some of these nuances maybe didn't cause a logjam prior, but now I know some folks have said for example when they move to Medicaid Managed Care, they had to hire a whole other billing person just to deal with all the billing issues to get claims submitted and prior auth and all these different things. So anyway, important to just read the contract.

Andrew Brenton Yes, and kind of on your point of prior auth, another thing that we often see in contracts that kind of behooves just taking a close examination, are the fact that many of these contracts tend to incorporate buyer reference documents and other information that aren't even in the four corners of the agreement, such as prior authorization, policies, procedures. The payor's provider manual will often be referenced in the amendment or in the contract, but the terms are not set forth there. So, you need to kind of do your own due diligence. Go on the payor's website, try to find these documents; anything that is going to be a referenced as a term in the agreement that is not in the agreement is going to be critical to understand as well.

Meg Pekarske And to pick up on something you said earlier is, who needs to understand this? You use the word leadership, right? So, this is more than just billing, right because I think often, we think of payor contracts like who needs to understand that. Oh, it's our billing department because they need to know

the special way to submit these claims and what's a clean claim and all this stuff.

But there's a lot of business considerations, like how's this going to impact your cashflow and some of the other things we're going to talk about that in terms of who in your organization needs to understand what everyone's agreeing to. It is probably that diverse set of your leadership team, because again as perhaps 60 percent of your revenue may end up coming out of this agreement. Right? Like that base contact has already been in place for 10 years. You're not going to get a new one because people who have had VBID contracts, they had contracts with this Medicare Advantage plan before. And so, as you said, it is just an amendment to that existing agreement. It's not a brand-new agreement. So that's obvious, but hopefully some wrinkles there about, you know, why it's worth the investment to understand what you're signing.

The next thing is about understanding your leverage, right? Some people may say "okay I'm not going to read this, because I'm not going to be able to change anything, so I'll just sign it and I want to get into the new frontier, so I'm just gonna sign this and then, you know, hope for the best." Obviously, our conversation on the first point should hopefully give you pause, but, you know, there are opportunities for negotiation, so why don't you talk about this leverage point?

Andrew Brenton Yep, yep, don't underestimate your potential leverage if you're – even if you are dealing with very large payers. Payers often have network adequacy obligations so, basically requirements to go out and contract with sufficient number of in network providers to care for their population, so they may have their own sort of requirements to contract with you, depending on whose all in your service area. Additionally, when we're talking about Medicare Advantage, if you are an out-of-network hospice for that plan, they still have to play traditional Medicare rates, so if they are trying to get you to agree to you know, sort of a haircut on the you know, the in-terms of treating hospice patients, so you are getting a haircut on the traditional Medicare rate. Well, if they don't contract with you, then they have to pay the full 100% of the Medicare rate so that could be another sort of leverage point; again, a lot of this sort of depends on your geography, how many other hospices are . . .

Meg Pekarske Isn't that, is that point, Andrew, just because of how Vidad works right now? But in the future that could change?

Andrew Brenton In the future that could change – yeah.

Meg Pekarske Yeah – yeah.

Andrew Brenton But currently, and I think even for the upcoming 2022 plan year, you know,

that is the case, that you would get the traditional Medicare rate if you're not in the *(interrupted)*

Meg Pekarske Yeah – yeah and well, I think that you know some of the things that you may ask for isn't the moon, right? When we talk about some of these other things, um, and so and I think obviously those folks who are in CON states, right – there is not that many people that are available to serve and I think you know from a very big picture standpoint you know the number of hospices may be decreasing over the next 5 years, right, and so for all the other forces that we talked about in other podcasts and the consolidation that is happening in the marketplace, so I think it's not worth spending time red-lining this contract and asking for some changes; because they may very well need you to and if you are the best quality provider in your area; you know, they want best quality providers – right – that makes them look better and what not, so what's the third one, Andrew?

Andrew Brenton The third has to do with just making sure that you understand the services that you are agreeing to provide, which may be beyond just hospice care, but the services as well as the payment terms for those services just to make sure that that fits within your organization that sort of meets your revenue needs, you know, so there is more to unpack here, but essentially you are probably going to be providing traditional hospice care – well where are you getting paid for that and the work that we've done on this, we are seeing payers try to make the hospice take a bit of a haircut off the Medicare rate. Well, how much is the haircut that you are being asked to take – uh are you getting paid not only for the full levels of care, their per diems for those, but are you also getting paid for physician visits or SIA? Sometimes that isn't always clear on the contracts that we have looked, and then are you also being asked to provide things that aren't traditional hospice care. This comes up more in the *(inaudible)* and the Medicare Advantage world, but we are seeing hospices being asked to provide in home respite care, being asked to provide transitional concurrent care coordination with essentially sort of working with non-hospice providers to ensure that the patient for a period after hospice election still has access to some curative treatment options as well.

Meg Pekarske Well – and I think, Andrew, on that point too, not only what those services are but who are the qualified people that have to provide that service, but when you are thinking about the financial impact of this contract in your organization – right, you don't want to sign something that you are going to go belly-up with, right – so what flexibility, because some of these things, right, when we talk about outside the hospice benefit, like this in home respite, is something that if you got to be *(inaudible)* contract that's in there, right? But who has to provide that service, and looking at that I think it says it can be a CAN; it doesn't need to be an RN, – right?

Andrew Brenton Right.

Meg Pekarske It is from the contracts we have seen, which obviously in terms of staffing shortages that are out there and you know all that stuff really important to understand what kinds of flexibilities you have, and then obviously we are working with a lot of folks who are not – the contracts that are coming up ae not the big kinds of contracts; they are per member per month sort of support care contracts, uh, to try to essentially do community-based palliative care for some big payors and what not, and so right now you are sort of writing your own service, right – this is – we are making up a sort of new model of care that is not necessarily defined yet, so what are you offering and what are their representations about the types of professionals, because obviously that mix is really important in understanding, to the point you made earlier, what the cost is for you to administer and how much of a haircut is this going to be and, you know, are some of the things I have to do. You talked about the coordination of care concurrent care, whatever . . .

Andrew Brenton Yep . . .

Meg Pekarske The contracts we're seeing, you know, you don't get paid for that, right?

Andrew Brenton Right, right, exactly.

Meg Pekarske Anyway, you know, I think again, it sort of seems like the obvious point about understand what you are getting paid for, but the wrinkle of who has to do this – right? Don't assume, especially when it is outside the Medicare Regulations for Hospice, that you have to staff it with a certain type of professional, so…

Andrew Brenton Right, right. Yeah, and sort of on this point as well, we are also seeing that not all terms in these paracontacts are really appliable to hospices, or I guess kinda specifically address hospice's professional responsibility obligations. We are not always seeing that *(inaudible)* to hospice is the one that is responsible for making eligibility determinations relatedness determinations, so that might be something else to look for and just to confirm that you are not going to be responsible if you don't authorize the service or if services aren't included in the plan of care. Just some sort of core hospice concepts that were not seeing always show up in these payor agreements.

Meg Pekarske Yeah, very good point. So, um, so the fourth thing is about over-payments, and you know I do a lot of speaking on audits, and this is one of the silver linings that with the potential carve-in to Medicare Advantage, and if you have high market Medicare Advantage, you now might house auditing, uh, you pick CPI all these audits that we deal with; is that going to be impacted because those are for Medicare fee for service, and when you are under

Medicare Advantage they have their own audit kind of functions, so that I think that really could look very different, and not that there won't be any, but it's going to be different, and you know there are some pros and cons, so tell me what you are seeing in this whole overpayment scenario with these paracontacts.

Andrew Brenton Just like you said, this is a lot different than Fee for Service Medicare where we have the four stages of the administrative appeals process, followed by an opportunity to take your payment dispute to Federal Court. We are not seeing that in these para-agreements rather you have to follow the payor's own internal grievance or appeals procedure, and if that doesn't work out for you, you got to go to binding arbitration. So, it's a lot of, you know, very different environments. We are also seeing some offset language, so this is when the payor determines that they made an over-payment to you, and then instead of just trying to collect the money from you directly, they will try to offset the over-payment against future payments owed to you. In the contracts that we've seen, the payor has a lot of rights, you know, a great ability I guess to do that, so it might make sense if that's how your contract reads to kinda try to push back a bit on that and maybe try to inject a bit more due process, such as more robust appeal rights into the contract so that you are, you know, you are sort of not at the whim of the payor sort of over-payment determination.

Meg Pekarske I think the point you are making here with off-set is important so – in traditional Medicare, right – if you get a multi-million-dollar audit, you have accelerated appeal rights that allow you to stay recoupment right off-sets like recoupment.

Andrew Brenton Yep.

Meg Pekarske Essentially what you are saying is, hey, there is no stay pending, you know, my appeal through even this grievance procedure, and I think you know is that something that you can push back on, or at least you got to be aware of that, right – that's immediate cash flow impact, and so, yeah, you're not going to be able to change the appeal rights of, you know, the payor right, you know, but in terms of when does that actually become due and where in the dispute process does that, you know, that off-set come into play, and so I think while auditing will look different because you can't stay off recoupment and other things, there could be, you know, different kinds of impact, and I think what you just said about the appeal process, I mean, people may say good and bad things about the Federal Appeals process, like, oh is it really independent and all that stuff, but you know, probably in comparison more independence?

Andrew Brenton Yes.

Meg Pekarske You know, I don't think you probably see the level of over-turn rate that we ultimately get at ALK in a private payor kind of relationship, and so I think that is the rules of the road and also you know, good or bad if you are always the squeaky wheel, like, they don't have to work with you, right, like this is, it's just different when you are managing a relationship, I mean lots of people don't think about, you know, when I bill Medicare this is a relationship, right, because it's like, it's like a *(inaudible)* willing provider standard – I'm Medicare certified, you have to pay me, and here it's like, well, if you are difficult as a provider to work with, you know, they don't necessarily, well if they have network adequacy they don't need to necessarily work with you, so.

Andrew Brenton Right, right.

Meg Pekarske So, I think um you know, hopefully, you know, that people will not find that there's a lot of disputes, like, so the things that we're talking about that there's not going to be you know, huge off-sets and giant audits coming out of these kinds of contracts, but just something to be aware of. So, as we close out, what's our fifth sort of take away?

Andrew Brenton Well, it's very apropos because we are talking about closing out of the managed care arrangement or your ability to do that. So in our experience we are not always seeing that hospices or providers are given the explicit ability to exit the managed care arrangement, or if they have that ability, it is really through terminating the underlying based agreement, which probably isn't something that you would want to do, or it's sort of an extreme, I guess, reaction. If you stay within the base agreement but get out of the managed care arrangement, that is probably preferred.

Meg Pekarske Well, and when you say that, you just mean the VPED contract, right?

Andrew Brenton Yes.

Meg Pekarske Like and so that essentially because the VPED is handled through an amendment if you're like, "hey this isn't really working for me, I don't want to be a part of this," you know, can you terminate the VPED amendment without saying, I'm never going to work with this payor for anything.

Andrew Brenton Exactly.

Meg Pekarske Or anything and so understanding that.

Yeah, exactly and you know, as you, and if you do in turn to one of these VPED amendments or VPED contracts, you know, and you find that maybe you aren't getting as much patient volume as you had thought, so maybe the haircut that you had to take on hospice, maybe that is kinda compounding, you know, your revenue issues, and maybe you don't really

want to be in the arrangement anymore, and maybe that is why it's important to understand your ability to get out of the VPED components of your payor contracts. Uh you know, and perhaps pushing back if, you know, the terms basically say that it's an indefinite duration that you have to be in this VPED component with the payor, maybe trying to push back on that, giving yourself some opportunity to exit the managed care portion of the payor contract.

Meg Pekarske I think the flip side though the payor can terminate with you. So, right – I think the way for folks to think about these things is what am I used to know – what's my current landscape, and then how is that going to change. So, right now, you have to be terminated from Medicare, right, to essentially not be able to get paid anymore, right, which, and there is a bunch of due process for you to get terminated from Medicare because it is essentially an any willing provider standard. If you maintain your Medicare certification, right, your pass your surveys, you do that stuff, you keep your enrollment, you can get paid; there is a sort of these rights. Well now you are in a private payor contract, and they could terminate it and they could terminate it for probably no cause, right? So back to the whole idea of relationship. This is a relationship, right? So, and I think that is sort of a different mindset than we maybe had before, you can be out of the game and again, when the full carve in actually happens, whenever that may come to be, and 60% of your patients are on Medicare Advantage Plans, and they are essentially, they have to get out of Medicare Advantage to come to you, how many people are really going to do that, right, because you are out of network, probably not that many, so I just think it is a different kind of mindset and you know, I don't think that payors are terminating their arrangement with providers all the time, but, know that there's a really different standard you have with what you are currently working on with Medicare. You might have had a contract, longstanding contract with payors and this has been fine, it's been in there, right, they could always terminate this, well, that's when you had a two-patient census with this payor, what if now 300 of your patients are subject to this contract and you lose this contract – where is your business, right?

Andrew Brenton Right.

Meg Pekarske And especially as more of our revenue may be coming from, you know, palliative care and what not, you know, our diversification, yes we are providing these different services, but are probably still going to be with a couple primary payors, right, and so it is a different mindset, and obviously the rest of healthcare has been dealing with this, I mean hospice is a bit unusual in that 90+% of our revenue comes from traditional Medicare. The shift in mindset I think is going to be more impactful for us, and so understanding how the contract can be terminated and what your rights are, you know, managing that relationship, trying to both I think defend your organization, right. That doesn't mean you just sign everything that's put in

front of you, but you need to try to work things out is what I think is ultimately . . .

Andrew Brenton Yep.

Meg Pekarske Um but any closing thoughts?

Andrew Brenton Not really, you know, this is sort of as we all know kind of where are things are headed in terms of, you know, the carve-in is coming and more of your revenue is going to be tied up in these managed care arrangements going forward so um – yeah just wanted to highlight these, uh um, kinda top considerations I guess for trying to think about, um, your relationship with these payors and how you might want to approach a contract if you are provided one.

Meg Pekarske So, and just to re-cap, you've got to read your contract, you've got to know how much leverage you have, understand what you have to provide and who has to provide that and how much you're going to get paid to do that so you can understand from a budget standpoint what that means for your organization, understand how over-payments and auditing happens, and then finally how can you exit an arrangement and both not how you – hospice can do that, but also how you can be exited from the arrangement. . .

Andrew Brenton Right.

Meg Pekarske And uh, and what is essentially perhaps no cause termination and what does that look like, so, well I think this will probably one of many conversations. This is an evolving area, and I think it is a really exciting opportunity, and I think payors are really open to how can they partner to provide great outcomes and provide care where patients want to be served, and we are the exact right people to help solve that problem. Right, we have awesome patient satisfaction. We are great at managing care in the home to a budget, so we are the people that can own the space of supportive care, palliative care, whatever you want to call it and survive *(inaudible)* too so we do have a lot of power *(inaudible)* and power so we have a lot of value to add and I think sort of own that space as an industry, but, you know, don't do it needlessly and just sign whatever you say, just and just a handshake, like oh that's good . . .

Andrew Brenton Right, right.

Meg Pekarske And whatever the contract says doesn't matter, because you know, this is, you know, a complicated arrangement, so uh well I, you are our one of our key people doing all these managed care contracts and what not, so I look forward as new things come up, I look forward to sharing these with our audience.

Andrew Brenton Yeah – absolutely.

Meg Pekarske Thanks for making the time, and look forward to hearing new insights you have.

Andrew Brenton Yeah – me too! Take care.

Meg Pekarske Well, that's it for today's episode of Hospice Insights: The Law and Beyond. Thank you for joining the conversation. To subscribe to our podcasts, visit our website at huschblackwell.com, or sign up wherever you get your podcasts. Until next time, may the wind be at your back.

END OF RECORDING.