Success Through Collaboration: Overview of Network Models for Hospices

Overview

Hospices are preparing for a future when traditional "hospice care" will no longer be the singular driver of the organization and a diverse mix of commercial payors, including Medicare Advantage plans, will make up their revenue stream. To succeed in this new landscape, independent hospices are looking for fresh ways to meet "Key Objectives":

1) create operational efficiencies and streamline costs;
2) expand geographic reach and service lines;
3) measure and benchmark quality and value; and
4) enhance payor contract relationships and diversify revenue streams

Increasingly, independent hospices are turning to collaboration building Independent Practice Associations ("IPAs") with other like-minded hospices as a strategy to achieve some or all these Key Objectives. These IPAs may also serve as Management Services Organizations ("MSO") for their participating hospices and provide them with additional services such as billing, quality management, customer service, records management, and data analytics support.

The following briefly describes and compares the most common IPA network models and to what extent they achieve the Key Objectives. Each model has different advantages and tradeoffs as well as legal and business consequences.[1] It is important to note that these models do not have to be mutually exclusive and hospices may find that their network model expands over time as the parties gain comfort and success with integrating resources.

Summary of Network Model Options

Messenger Model Network

The least integrated of the network models, this form of IPA is a limited purpose arrangement designed solely to facilitate contracting between providers and payors and avoid price-fixing agreements among competing network providers. This model is designed simply to minimize the costs associated with the contracting process and does not negotiate prices on behalf of individual providers. However, Messenger model IPAs may be allowed the authority to accept payor contract offers on a participating provider's behalf based on certain contractual parameters. This form of IPA may also help providers understand the contract terms offered by payors. While the Messenger model may offer additional services to participating providers through separate service contracts, hospices retain strategic and operational control over their organizations.

When Does this Option "Make Sense"?

- When my primary concern is how I can continue to provide the hospice benefit to a wider variety of payors (including Medicare Advantage and commercial plans).
- When I plan to retain my current service offerings and I am not focused on offering upstream services (such as non-hospice palliative care).
- When I am concerned that my size, or geographic coverage area, is too small to be attractive to a wide variety of payors.

[1] This document does not identify or analyze the various federal and state legal considerations, including nonprofit and anti-trust issues, which must be evaluated to determine whether a particular model is permissible and the best organizational structure for a specific situation.

Summary of Network Model Options (cont.)

Financially Integrated Network

Requiring significant trust and collaboration among participating providers, this form of IPA is characterized by providers using common budgetary tools and metrics to effectively manage a combined patient population. Through significant cooperation and investment, providers may share in the savings achieved through improved disease management, coordination of care, and effective use of resources. To be successful, participating providers must play an active role in managing cost-of-care for the collective patient population. Providers who chose to financially integrate often also choose to clinically integrate.

The extensive amount of collaboration required may make it difficult for a network to effectively manage cost-of-care without sharing clinical best practices. As such, providers must also consider the implications on clinical staff as well as scope of practice limitations, physician (and other provider) compensation arrangements, technical support, and data analysis capabilities. Many payors find "risk" and performance-based reimbursement contracts with financially integrated IPA's attractive including Medicare Advantage plans, Medicaid plans, and commercial insurers.

When Does this Option "Make Sense"?

- When my goal is to use available resources to achieve efficiencies that increase my organization's impact, expand my service capabilities, reduce administrative expenses, or enhance quality.
- When I am interested in contracting with a payor using a per member per month, capitated, or other value-based compensation reimbursement method.
- When I am able to invest significant time and resources towards the joint effort.

Clinically Integrated Network ("CIN")

Requiring significant trust and collaboration among participating providers, this form of IPA is characterized by providers working together, using best practices and common standards, to improve patient care, reduce operational costs, and strengthen market presence. Through significant cooperation and investment, providers create an interdependent system to control costs and ensure quality patient care. Joint contracting is an integral component of achieving the CIN's clinical goals, but is not the primary purpose of the CIN. To be successful, participating providers must play an active role in defining quality and determining performance metrics. Providers who form CINs may also choose to financially integrate, though "risk" based contracting is not a prerequisite to a successful CIN. Many payors find "risk" and performance-based reimbursement contracts with CINs attractive including Medicare Advantage plans, Medicaid plans, and commercial insurers.

When Does this Option "Make Sense"?

- When my goal is to increase my access to, or leverage my current capabilities for, shared evidence-based clinical practice guidelines, care management platforms, or data analytics.
- When I am interested in closely collaborating with other providers in my specialty.
- When I am able to invest significant time and resources towards the joint effort.

Common Ownership

Providers agree to form an entity which becomes the parent company/sole member of each hospice. The parent company then contracts with payors as well as provides agreed upon services to participating hospices. Hospices each hold equity in the parent company and receive distributions based on agreed upon terms. Specific issues regarding exclusive contracting with payors, as well as the total market power of the combined organization must be considered when providers combine under common ownership.

When Does this Option "Make Sense"?

- When I have a short timeline to access additional resources or make necessary expense reductions.
- When I want to retain focus on delivering care, or do not have the time or resources to invest in a collaborative effort.

Comparing Model Options Based on Key Objectives

Key Objective Achieved?	Messenger Model Network	Financially Integrated Network	Clinically Integrated Network ("CIN")	Vertically Integrated Entity (Common Ownership)
Enhanced Payor Contract Relationships and Diversify Revenue Streams?	**Yes, in a limited way**. This Model does allow the centralizing of the payor contracting function, but there are important limitations. • Network cannot negotiate prices with payors on behalf of participating hospices. • Payors may still require individual members to contract directly for credentialing purposes. • Limited functionality on contracting as well as the lack of integration in other areas likely limits payor contracting to a traditional fee-for-service contracting approach.	**Enables a wider variety of contracting options.** While financial integration and clinical integration each require different types of investment, both should be considered when evaluating revenue objectives: • Both options support "risk-based" payor contracting and shared performance objectives including alternative payment models, such as per member, per month contracts. • Network may mandate integration or require compliance with agreed-upon standards as a condition of participation. • Networks may provide services to participating hospices which involve establishing and monitoring contract performance on both an individual and Network basis. • Both options require long-term commitment and may require significant changes to current organizational structure. • Participating hospices retain independence as well as control over all functions outside the scope of the Network. • However, despite Network's increased role in contracting, payors may still require individual hospices to contract directly for credentialing purposes.		**Yes, provided parent company is sufficiently resourced to support subsidiary organizations.** Common ownership can achieve many of the same objectives as an integrated network but will require significant revenue structure changes for an individual hospice. • Larger organizational reach may be an attractive service delivery model for payors that require limited networks. • Parent company may compel financial, or clinical integration, or both. • The level of independence retained by individual hospices related to payor contracting and reimbursement may be significant.
Expanded Geographic Reach and Increased Service Capabilities?	**No.** The Messenger Model does not expand an individual participating hospice's area as it is a single purpose vehicle for payor contracting. • Allows smaller and rural providers to access a larger pool of payors. • Without clinical or financial integration, unable to offer a uniform non-hospice palliative care service to payors.	**Network may benefit participating hospices,** through a single, unified, cohesive network brand with respect to relationships with payors and common standards. • Can offer standardized coverage over a geographic service area that is larger than any individual member. • Can offer a standardized non-hospice palliative care service. • Requires significant investment to ensure technology enables accurate data capture and reporting.		**Yes, potentially.** Common ownership may allow the parent entity to leverage different capabilities of subsidiary hospices. • Attractive service delivery model for larger payors. • Hospices may give up some independence but may have a "voice" in the combined control of the parent.

Comparing Model Options Based on Key Objectives (cont.)

Key Objective Achieved?	Messenger Model Network	Financially Integrated Network	Clinically Integrated Network ("CIN")	Vertically Integrated Entity (Common Ownership)
Measurable Quality and Value-Based Benchmarks Available?	**No, not a network function.** Model allows for greater access to a variety of payors; however, hospices retain control over reimbursement and operations functions. • Each hospice negotiates on its own when contracting with payors.	**Yes.** Model allows hospices to share accountability for cost-of-care of combined patient populations. • Network may additionally contract with hospices as an MSO for services to manage cost-of-care. Model enables participation in new and innovative service delivery models that are targeted for specific populations. Integration encourages hospices to implement interdependent systems that promote high-quality care in a cost-efficient manner. • The level of integration, or services offered by an integrated Network can change based on individual hospice needs. • Integration may require significant capital investment to support the shared clinical services.		**Yes, provided parent company is sufficiently resourced to support subsidiary organizations.** Parent entity may contract with subsidiary hospice organizations, as MSO, for a variety of clinically supportive services.
Cost Savings and Operational Efficiencies Created?	**Very limited.** As Model is limited to payor contracting, it is not positioned to reduce in expenses outside payor contracting costs. • Reimbursement rates may vary among participating hospices. • However, Network can separately contract with hospices as a Managed Services Organization ("MSO") for additional services which are designed to reduce administrative costs.	**Yes, potentially.** Model encourages using shared resources to achieve savings in both cost-of-care and administrative areas. • Network may monitor compliance with performance metrics. • Requires significant level of trust and agreement among participants to be successful. • Integration may require significant capital investment to enable shared accountability.		**Yes, potentially.** Model changes organizational structure of hospices which allows for some costs to be assumed by parent entity. • Parent contracts with subsidiary hospices, as MSO, for a variety of administrative and non-clinical services. • Enables separate organizations to share a common governance structure.

Meg Pekarske
Hospice Practice Group Leader
Partner | Madison, WI
608.234.6014
meg.pekarske@huschblackwell.com

Noreen Vergara
Healthcare Practice Group Member
Senior Counsel | Kansas City, MO
816.983.8252
noreeen.vergara@huschblackwell.com