Hospice Insights: The Law and Beyond

Episode 42: Strategic Restructuring for the Future, Succeeding in Value-Based Care: How Hospices Can Collaborate Through Network Models

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Meg Pekarske Hello and welcome to Hospice Insights: The Law and Beyond where we connect you with what matters in the everchanging world of hospice and palliative care. Succeeding in value-based care; how hospices can collaborate through network models. Today I'm joined by the newest member of our hospice and palliative care team, Noreen Vergara. We discuss different ways hospices can come together to succeed in the value-based care landscape. We explore a continuum of options from messenger model networks to networks that are clinically and financially integrated. All the way to common ownership through merger acquisition. While there's no one size fits all approach, collaboration can be a fresh way to create operational efficiencies and streamline costs, expand geographic reach and benchmark quality, all of which are critical to enhancing pair relationships. I hope you enjoy this rich conversation and don't forget to download our companion hospice tool for this episode, called Overview of Network Models for Hospices on the Husch Blackwell Hospice Resource Center.

Welcome, Noreen, and thank you for joining us.

Noreen Vergara Thank you for having me, Meg.

Meg Pekarske Or I should say, me I guess, me, thanks for joining me. And it's been so fun to work with you, you joined our team a little bit ago specifically to help with all of the work we were getting in on the joint ventures front and joint venture more in this collaboration opportunities because you had a lot of background in this, and maybe just since you're a new member of our team and new to our audience, maybe you can give a little bit of background on all the experience you bring to managed care and value-based contracting.

Noreen Vergara Sure. I'm happy to walk through it a little bit. So yes, I came to Husch just about three months ago, and so far it's been a really fantastic experience,

and I loved getting to know kind of the hospice clients and the different types of work that you all have kind of running through your doors. My background has been primarily on the payer side. And that means anything from commercial health plans to Medicare Advantage to Medicaid programs. Any kind of relationship with a provider, fee for service, pay for performance. I've done a lot of different types of contracting, and really I've spent a lot of time in the payer world. So I'm excited to bring that to Husch.

Meg Pekarske

And we're so happy to have you because where your experience is, is where hospice is increasingly going with the eventual carve into Medicare Advantage. But I think even more importantly is this whole non-hospice palliative care and just there is now interest by payers in, you know, not just patients who maybe have a six-month prognosis, but how do we manage chronic illness and advanced illness, and hospices have great skills to do that and we can do that to a budget. But it is converting some of our data and how we talk about what we do and the payer mindset that I think we need to, you know, build that knowledge base so having you on our team is incredibly helpful. And what I wanted to explore mostly today is not just, okay, what does a payer contract look like, but I think the more strategic issue that we're dealing with a lot of hospice clients with is, how do I look more attractive to payers? And what we mean by that is, I am a standalone hospice in, you know, Colorado or Missouri or whatever. I serve this region of my state; are they going to be interested in contracting with me? Even if I have, when we talk about getting upstream, you know, I have a palliative care program, but I only cover four of the 80 counties in my state. Are they really going to be interested in working with me? And that's a question that a lot of our clients have been coming to us with. How, if I am a standalone hospice, could I sort of get bigger? Not necessarily by merging with other hospices but creating a network or a collaboration, and that's where you know this hand-out that we're going to use sort of as a guide through this conversation but also available for download really sort of captures this kind of coming together and creating networks, which I think that when we think about it from a very sort of larger lens, lot of other provider groups had been down this road before. It's just new to hospice. Which I mean none of this stuff is new to you. It's just sort of new to our hospice clients. So I want to talk through the different ways you may come together but maybe just to kick it off, because as you and I have been kicking around this, you know, to talk to clients about these issues. I think we've really structured our evaluation of what might be best for you based on four things, four objectives that I think in my experience working with hospices all these years and working with a lot of clients that are looking at how do I stay relevant and into the future. There are four things that are on people's bucket lists that they are trying to achieve. They want to create that operational efficiency and streamlined cost. They want to be able to expand their geographic reach and also offer more services. And three measure and benchmark quality and value. I mean value-based care is the

word of the day.

Noreen Vergara Yeah it's the word of the day.

Meg Pekarske And then four is sort of the roll up to all of this is, how do I become more attractive to payers and essentially be better able to diversify my revenue stream so I'm not so reliant on the Medicare hospice benefit. Which is going to be changing in the near term. So we'll come back to these four objectives throughout the conversation but I wanted to lay that out. So tell me, and I think let's go from sort of least integrated to most integrated. What is sort of the first way people might be able to come together?

Noreen Vergara Sure, so before I jump into the different model options going from kind of least to most. I think for the listeners one of the things at least that I think about when exploring what kind of model fits best for any particular group of people it's integration, it's cost, we're in a tech enabled world and it's expensive so how can you leverage that? And it's the importance of planning. Working together whether you know you're financially integrating or maybe clinically integrating or going through some sort of merger change of control. Those are all big events in an organization's life cycle, and I just don't want to, you can't underestimate or overstate the importance of thinking through what you need and then planning for it. Kind of from the easiest network model it would definitely be the messenger model. It's been around a long time and this type of collaboration or this type of collaborative model. You have a group of providers that come together for the purpose of contracting with a payer but all that messenger model can really do is serve as a go-between. So a payer wants to contract with hospices in Colorado or Missouri, wherever you mentioned. And they're looking to fill an access need. They need to fill their gaps of where their membership is. And hospices can use what's, you know, kind of a very routine common model of working together in forming a messenger model. And this just enables kind of reduced contracting cost some increased administrative efficiencies, but that's about as far as it goes. Messenger model can't negotiate price on behalf of the hospice. It's very limited in what it can achieve.

Meg Pekarske And I think what you said early on, and I think this is why I was very eager to do this podcast and this is under our big series strategic restructuring for the future. Which we're really talking about ways that hospices can pivot and essentially view their business a little bit differently into the future. It's not and I don't think we should think of this as how am I going to survive with Medicare Advantage carve in? That is one piece of the puzzle, but it is not the only reason that I think we need to talk about. You know, commercial payers, I think it's actually more interesting to talk about it in terms of non-hospice palliative care needs opportunities to get upstream. So I think this is not a current kind of turn key of things; I mean, Noreen, I've worked through these issues; you have too. This is months and

months—

Noreen Vergara Right, commitment.

Meg Pekarske —of working through this. You know in all of my years every time we start talking about collaboration between providers and that could be like a management services organization, which we're going to sort of touch on as sort of an off shoot of some of these things, is like my independence and I don't want to lose my independence and how I want to, I've existed since 1983 and I don't want to give that up. And so I think, you know, you need to probably soften that thinking, and some of the things we're talking about here is not necessarily giving up your independence. You're actually going to be able to get more for what you're doing and obviously having common ownership is on the far end, but these earlier network opportunities you're not changing your name, you're not changing who you serve in your community and all of that stuff. But I just wanted to echo what you're saying now is the time to do this.

Noreen Vergara Right, this takes time.

Meg Pekarske We need to motor as an industry in thinking about how are we going to start viewing our business, and we haven't really thought about partnership, and I think it's been defined by the hospice benefit and Medicare, so you know 90 plus percent of our revenue comes from Medicare and we're paid a per diem and there is no negotiation, the rate just goes up every year. I'm sure I have to report quality data, but times are changing. I mean the Medicare hospice benefit, you know, assuming the carve in goes through isn't going to work that way. And we may in the future may be much more defined by the hospice benefit might become much, much smaller part of what we do because there's now all of these opportunities with payers to manage their chronically ill patients that aren't maybe terminally ill as we would define it under hospice law but really need our services and so that's the future. And so folks who don't have a palliative care program, I mean, they may be trying to do that at the same time trying to come together with other providers who are also on going to create a palliative care program, so what you're going at and selling to these payers. So when we talk about these networks like the messenger model. It might not be just for hospice, right?

Noreen Vergara No.

Meg Pekarske It's probably likely going to be.

Noreen Vergara It could be for any service.

Meg Pekarske For yeah, chronic care management advanced illness like supportive care management, I mean all of these names, I mean it's just whatever bundle of services that you can get for per member per month from a payer, and so

anyway I think your point is really well taken, and so this messenger model, and I mean there is no magic with these words. I mean, I think most people don't, I mean lawyers refer to this as messenger model, but I don't know the industry folks would necessarily say that.

Noreen Vergara Right.

Meg Pekarske So why would one, so you said you can't negotiate price. I'm not really going to get tons of operational or administrative efficiencies; why would one do this?

Noreen Vergara Why would you want to do a messenger model? I think when you think you've got a good program, you like what you're doing, you like your population, you want to continue to offer services, but maybe you want to expand your reach. Or you know that Medicare Advantage and other payers are coming into your market, and you want to explore the possibility of whether they may want a contract with you. If you're a smaller organization this may be challenging. Because a payer is going to be looking for providers who meet maybe a certain size or a certain scale or have a certain set of capabilities in order to put them in their network. So joining a messenger model or kind of a very, a looser integrated model with other like minded providers you are showcasing yourself I guess. You are saying, hey I'm here, I'm willing to play, I'm willing to negotiate, I'm willing to do some stuff. But it's a maybe a baby step. It's certainly, I think of the possibilities, it's the least operational lift, because you're not really doing anything differently other than using a combined organization to contract on your behalf and pass on information to you.

Meg Pekarske I think that's really helpful, and in terms of the nuts and bolts of how you implement this. When we work with people you are creating a legal entity.

Noreen Vergara A new legal entity, yes.

Meg Pekarske A new legal entity that all of these hospices join into, and that new entity has contracts with someone or employs someone who is going to go create the relationships with the payers. So that's a lift this can help with too. Like you know, I have a 150-patient hospice I've never really worked with private payers. I don't have any relationships. The idea is you can sort of pull resources and hire someone who can develop those contacts with payers and, you know, start having those conversations with payers, and so it does like you said.

Noreen Vergara It helps with volume. I guess too. I think the current the Medicare demonstration project, right now there's something like 53 plans currently in kind of the demonstration project to explore the carving and hospice to Medicare Advantage. That's a lot of plans and that's only going to grow. That can get, I mean that's a lot of administrative burden when you've got

annual renewals. You've got credentialing cycles. It's constant. So certainly a messenger model or kind of a pass through network model can help with that.

Meg Pekarske When I was talking to a CEO a couple of weeks ago and they were talking about just, you know, Medicaid managed care, which is now nearly ubiquitous, I think every state has it. The administrative burden they had to hire another billing person full time to handle these different managed care contracts. Because where they fell in the state, they had multiple payers to deal with. And so every payer is going to be different, so I think your point about plans and is like one plan is one plan and they do things one way and then this other way, and so the messenger model you might be able to pool some resources to help streamline some of.

Noreen Vergara And help with some of the complexity. Because you're right, one plan is one plan, and Medicare Advantage plans kind of on the whole function more like a commercial payer or commercial insurance plan than, you know, straight Medicare part A or part B. So you've got they'll have different quality metric, different billing requirements, different codes. There's a lot of flexibility and a lot of options to choose from, but the flip side of a lot of options to choose from is, well you've got a lot of options to choose from, and that requires time and attention and resources.

Meg Pekarske Let's start talking about, and I think this becomes more important if you're looking at I want to create a network, because I'm thinking about how I can get upstream and do non-hospice palliative care, and we've worked with people who have created a clinically integrated network for palliative care so, you know, because there aren't as many opportunities right now because we haven't been carved into Medicare Advantage on the hospice side of things. But it's really, hey, palliative isn't defined. It's really defined by what I can get paid to do. What can I sell to payers and then say to payers we can offer this service and we can offer this service over X% of our state or whatever, and it’s going to meet these metrics and it’s going to look like this and they were able to sell this to payers because they had a lot of clinical integration. And so, and this really enables you to do more, and again I think this is what's interesting, is if you are trying to get upstream, how you could define again palliative care, supportive care, whatever this is. I think you want to be more clinically integrated to be able to sell that. Because when you're creating a new service, right? Because you're trying to sell something that doesn't exist yet. Being able to say, we're going to provide this the same throughout this entire state

Noreen Vergara It goes a long way.

Meg Pekarske With seven eight or nine providers in the mix here. We're all going to do it the same way. And we're working these metrics. Can you tell me a little bit

more about what does a clinically integrated network mean?

Noreen Vergara Okay so I think one of the exciting things about integrating, at least I think, is the opportunity to be creative and do new and different things as a way to manage, you know, total cost of care or total quality of care for an entire population. And clinically integrated networks enable providers to do this. And this isn't just happening in hospice. This is happening all over healthcare. But essentially if you're looking to integrate clinically, this means that a group of hospices however many there are, five, six, seven, eight, fifteen, however many there are, have decided to collectively adhere to the same best practices, the same criteria set, generally they use the same electronic medical records so they can share data across each other and keep each other informed about the care of the population or the care of their patients. Generally where I see clinically integrated networks succeeding and doing well are those providers who are interested in coming up with new service lines. Who are interested in kind of pushing integration forward, pushing whole person care forward and developing ways to get out of the little box that you know fee for service care has had providers in for however long fee for service care has been around. But that's something that I think Medicare Advantage and once it gets carved in is going to be so great. Is because that's what those plans are looking for as well. That's how they are reimbursed, that's how they achieve stars and good quality ratings is through cost savings and integrated care and good quality, and so clinically integrated network enables like-minded providers to kind of join, lock arms and say this is how we want to manage care on a clinical basis. The effect of that really also means you have to clinically integrate. You talked earlier about providers maintaining their independence and maintaining how they want to be doing it since the mid-80s and they like and everything is working for them. Integration clinically or financially requires compromise, it requires a little bit of give, a heck of a lot of investment and continuous joint, I guess, commitment to whatever kind of standards you agree upon. Kind of best practices. Really and whatever market you're looking for. So it’s very exciting but it's definitely not easy.

Meg Pekarske You know, I've been a part of many of these conversations and when you say long. It is long.

Noreen Vergara It is long, yeah.

Meg Pekarske Obviously as a lawyer you're not involved in all of these meetings because that's cost prohibitive, but you know people have to sort out the issues themselves and then we can help effectuate that. But even within these broad categories there are lots of different ways to do it, and there are a lot of more corporate issues about do you want this entity to be non-profit or not? And there's a lot of corporate stuff related, because even with a clinically integrated network again you're creating a new entity. How is

that going to be governed? And what are people's contributions? And so there are a lot of corporate things to think about in addition to sort of the quality benchmark standard. So there's runway here which is I think why you need to probably get on this train.

Noreen Vergara If you're thinking about it, start planning. We kind of entered this conversation talking about payers and Medicare Advantage and how do you get access to it. I think clinically integrated networks and financially integrated networks, may be even more important than how are you going to make money and how are you going to be reimbursed. is whether you can agree and integrate with the other providers in your network. Because again you're forming a separate entity and then you're going to have to delegate certain functions and authority to that entity. So what's that going to look like? Because you are giving up, it's maybe not independence, you certainly are saying, you know, hey network, you have the ability to hold me to account in certain areas and hold my integrated partners to account in certain areas, and that takes a lot of negotiation and a lot of thinking things through.

Meg Pekarske And I think that there needs to be a level of humility, right?

Noreen Vergara Sure.

Meg Pekarske You can't, you may be the CEO of a hospice but like you can't be the boss of everyone else, right? You essentially have a bunch of bosses sitting around the table and like I think there is, a greater good is and when we talk about common ownership I mean this also is hard,. is everyone wants to know who the CEO and who is in charge. And if everyone wants to be in charge, like then no one's in charge, right? So I think that I think something that we've had to work through with clients before, and I think like as a common stumbling block sometimes is who's in charge because everyone wants to be running the show.

Noreen Vergara Right. What are you all going to contribute to it?

Meg Pekarske Yeah exactly, and I think that you can't just be, oh I don't care, I'm just along for the ride, because you do have to be invested, and even if you're not in charge there is a ton of work to be doing as a member of this and you know commitments that you make that you then have to go home and operationalize, right? And what not so and we have clinical integrated settings or network and financially integrated network. I mean they're close, and I think everyone wants to get that per member per month or otherwise.

Noreen Vergara Some sort of complication.

Meg Pekarske Yeah and so what, let's talk about financially integrated, and how does that

better enable you to get like a per member per month contract?

Noreen Vergara Sure, I guess financial integration and clinical integration, we're talking about them separately here for I guess illustrative purposes. But they're not necessarily two exclusive separate things. You can have financial integration and you can have clinical integration. They need to be considered together. I don't know that you'd want to pull your money and financially integrate and take "risk" on a population without any clinical integration. These two things go together. And to some extent any time when you pool resources and take a common kind of risk pool you're going to need to make sure that you have the resources and the capabilities to be able to carry it out. So for financial integration, I mean really it's kind of what it sounds like, is that the providers are contracting with a payer and they have seeded resources or given authority to the separate entity, the network, to do that for them. But they are also sharing bonus potential maybe? Or penalty potential maybe? The dollar and how much they receive from any payment isn't necessarily all on them. Based on how well they do their work. There's some element of collective accountability for you know, is it quality? Is it reduced cost of care? Is it some sort of shared savings because you've pooled so many of your operational capabilities together than you can really dramatically lower your cost of doing business. So you're able to do more with less and kind of share that money. That's really financial integration. I don't know how often your listeners and how familiar they are with, you know, PMPM sort of risk pool type arrangements on the commercial side. But certainly that's very attractive to, I guess, a palliative care program or really with Medicare Advantage where the payer is looking to feed or to refer or to make available palliative care and hospice resources to patients maybe earlier in the disease progression. To help bring down the cost of care for other conditions overall. So that's really what financial integration enables a provider to do is to, I guess, scale resources efficiently. But it is, you know, air quotes "risky".

Meg Pekarske I think with this clinical and financial integration. I mentioned management services organizations, which you know we didn't have a separate bucket for this because sometimes this new entity will sort of serve perhaps as a management services organization, which is just a fancy way of saying we are going back to key objectives. I want to reduce my costs, I want to create administrative efficiencies, and maybe this new entity that's, you know, the network provider can also do some, whether it be like, hey we joined together for IT or billing or you know essentially a variety of back office kind of things. That might be helpful to all of the members and lower costs. Because I think as people look at the horizon here with a carve in to Medicare Advantage for hospice, a pretty significant pay cut from their current Medicare part A rates. So yes, you can make that up in volume, but you're also going to have to find ways to lower your per day costs.

Noreen Vergara Hence the planning runway that we've come to. These are big endeavors for anyone really to try to wrap their arms around. Reducing costs and potentially taking a pay cut and increase volume of patients. Each of those is huge. And then to do it all together? I guess the upside is really attractive and there's tremendous potential, but you can't underestimate the need for planning over a long period of time because this is a big bite to bite off.

Meg Pekarske Yeah well, and I think that everything doesn't have to happen tomorrow. But if you're working on this and you're talking with others and again being at the table involved in a lot of these discussions and lots of different projects across the country, I mean you come together maybe there's 8 of you but then as talks go on, some people shave off. I'm not that into it or my board's not that invested in it whatever. Because I think the folks that we're typically working with here are smaller midsize hospices who are essentially, my geography is sort of limited. So what do payers want? They want to say I want a contract with one person, like one entity, and then I cover the whole state and I'm generally good. Right? That makes their job easier, and so if you're looking at, I only cover a small part of this; how do I compete for those contracts? And this obviously enables you to do that even though I'm not increasing my, like I'm not getting another Medicare provider number or expanding my service area in this state. You are because you are coming under an umbrella with other folks. It allows you to get the benefit of saying it's not *I* can cover; it's *we* can cover this. So you get the scale that some very, very large providers can sell. Like if I'm in thirty states or something and I'm going to have different leverage with payers than I might have if I'm just a single site hospice. So how do single site hospices continue to play the game?

Noreen Vergara One thing you mentioned that we didn't really hit that kind of was a good lead in about how kind of smaller or single area providers can compete that we didn't mention is, you know, these solutions, be it messenger models or financial integration or clinical integration. This doesn't mean that providers can join together and do anything that they want. There are very strict anti-trust rules in place to prevent providers from, well, to promote competition and prevent anti-competitive effects from providers that are working together. That being said and I wanted to put that out there. These different options are ways that you can do it where you know the regulators have looked at it and said, okay, yes, we value competition. None of that changes. But the benefits of integrating this way, the benefits of working together this way, outweigh the potential anti-competitive effects of it. And we'll give it a shot. We'll take a look at it kind of under a more reasonable standard. So I don't want to give the impression that you just band together and you're able to compete. In a way yes, but like with everything it's always much more complicated and long.

Meg Pekarske A lot of legal stuff.

Noreen Vergara Lots of legal stuff.

Meg Pekarske So exactly, and there can be state law issues. If you're taking on risk there can be insurance considerations. There can be licensing issues, like what service are you providing and what do you need to be licensed?

Noreen Vergara Who's providing it? Yeah what kind of licensure clinician do you have providing it, and can you do that? Who knows?

Meg Pekarske You're exactly right, and then all the corporate considerations and governance considerations and all of that.

Noreen Vergara Planning, planning, planning.

Meg Pekarske Exactly. But again we've worked through this process successfully with lots of different folks, so I mean I still think it's fairly new for hospices. I think that the last thing I want to touch on is common ownership. I mean the, we had an earlier podcast and it was the kick off podcast of this series on strategic restructuring where we talked with Mark Kulich about what's the state of the market and just all of the consolidation going on in hospice and obviously a lot of on the for profit side, but there's a lot of coming together under an umbrella that's happening on the not for profit side, and we've gotten involved in many projects of that nature too. Where it is, you know, for crudeness here. There's a new owner. Like that whole coming full circle here like this independence. I mean there can, and you can work through some of this with governance, but there in non-profit world you call it member substitution, right? There's a new entity that's like the parent and they're going to become the sole member of each hospice under that umbrella is typically how those function, and obviously on the for profit side it's just a straight up merger acquisition, whatever that is. And I think that's a way to achieve some of these same objectives, like quality benchmarking, data analytics, administrative efficiencies. It's a way to do that. But you are giving up some more of that. But I think in some of the situations we've been dealing with, there's been a leadership change at one of the entities. And finding a strong leader that given everything that's on the plate of a hospice CEO these days. Like you need to find someone who's going to replace them that's going to be energetic, sees the potential of the future and know how to get things done. And leaders like that are not just growing on trees, and depending on where you live it could be hard to recruit someone like that. So some of the not for profit side of the house. Some of it is leadership transition is sort of one of the reasons that people are saying maybe we should come together.

Noreen Vergara Really come together.

Meg Pekarske Yeah. And obviously that's not the only reason, but its been a theme in some of the deals that we worked on. But tell me a little bit about from a

payer contracting perspective, what is common ownership get you?

Noreen Vergara Well from a payer perspective, it gets you to the same place that a clinically integrated network or financially integrated network would probably get you. Because the new parent, or new member, effectively has the ability to mandate or force integration downstream. That is a very straightforward to integrate, very top down kind of managerial way to do it. From a how do we get paid and what kind of contract would be attractive to a payer. I think that common ownership, that's going to appeal to some of the really big payers. Because you're able, depending on the size of how many hospices are under this joint common ownership umbrella, you can really cover a lot of geographic space. And that is always attractive to a payer. More bang for less administrative dollar. That's always good. But again I think it comes back to what makes sense operationally, and from a governance perspective for the individual hospice. What are you trying to get out of this? If you've got maybe a short runway to whether it's a leadership change or gosh maybe a staffing issue or capabilities. You just don't have the funds or the resources to pull together to share ownership of an EMR or other types of investment that a network just will require. Common ownership is a way to get there really pretty quickly. And certainly that its happening all over the place and hospice and healthcare beyond. Lot of activity going on.

Meg Pekarske Right, that's just easy peasy, right? Just pick your option.

Noreen Vergara But it's a lot of work.

Meg Pekarske I think this overview and we the hospice tool that we're posting goes into this and has a comparison chart about like when this might make sense for you and it breaks down those key objectives those, the geography the administrative savings, the benchmarking. Those types of things. It compares the different models based on what things you're trying to achieve.

Noreen Vergara Yeah your objectives. Which that is the most important thing. Figuring out a way to collaborate in a way that meets your needs. Cause there's a heck of a lot of options out there. And even within one of these clinically integrated models, there's probably an infinite number of ways you can clinically integrate. Just based on what you and your hospice partners, what you want to achieve. And then if you bring on palliative care. What does that bring you? And then gosh you contract with a Medicare Advantage Plan that is very into value-based care and episodic treatments and care. What does that bring you? So it just builds on each other. I can't understate the importance of figuring out what you want and then planning for it. Spending a lot of time really thinking through what are your objectives, and what do you want to get out of this?

Meg Pekarske I think that's a great way as we conclude to emphasize that point. These are not the legal issues. These are not lawyer-driven decisions. It's you need to sort of figure that out and I think, you know, your counsel can be a guide for some of the questions.

Noreen Vergara Help you avoid potholes and yeah.

Meg Pekarske Obviously once you decide like, hey this what we're thinking, obviously there's legal issues like anti-trust, licensing, insurance,

Noreen Vergara Governance.

Meg Pekarske Those types of things. Governance. That we'll need. But they're not the answers to the questions necessarily. So I think that's sometimes frustrating for people. Well don't you have the answer? You said you worked on these before; just do the same thing. I think every one that we work on, they're all different.

Noreen Vergara And they're long term solutions. Whatever you decide, I don't want to say you're stuck with it because you can evolve and change and adjust, but in a way you sort of are stuck with it, at least for a contract term or some period of time where you've agreed to see some kind of network integration model through. You committed. Think about it ahead of time, really think about it ahead of time.

Meg Pekarske Yeah. I think lawyers can be advisors on this and help you implement your idea, but it doesn't replace all of the players coming together and getting comfortable. Can we work together? And where you begin is not where you end up necessarily. I think oftentimes people have thought of getting together for something more discrete and then it becomes bigger, or likewise we started bigger but now people are less interested in that and now we're shifting more to a messenger model, and so I think it really depends on the players, and I think obviously folks have boards here and your boards needs to be on board with where things are going.

Noreen Vergara You can always start with the messenger model to get your feet wet and to get comfortable with the contracting process and working together through a network. And integration, it doesn't all have to happen at once. You can start with a messenger model if you want to clinically integrate to some extent, then when you feel you've got that kind of handled, bring on a little bit of, you know, financial integration. It doesn't have to be hands off or full risk. Those aren't your only two options.

Meg Pekarske No, and these are just like everyone else, lawyers need to learn new things and, you know, this has been fun to learn new things putting the hospice lens on, you know, what other parts of the industry have gone through before. So it's been great to have you on the team and because you were a CEO too you understand the business side of it, not just the legal side of it

in terms of how painful those discussions and how long those meetings are and what it takes to sort of get there. So I think that's been really invaluable to clients as we've been talking through this.

Noreen Vergara Sure, and those conversations don't ever end. You know, once you've got the network and you've got the payer contract, well then you've got to try to meet the benchmarks. Then you've got to, because there's something at the end, value-based services or value-based contracting is intended to produce value. So you're trying to work towards that and that involves, I mean, yeah that's not legal. That's often hard discussions with your CFO, hard discussions with your CEO or your board. Or maybe the board of this joint venture you've put together to handle this stuff to make sure that gosh now that you've integrated or now that you're all working together that you actually can make it succeed.

Meg Pekarske That's exactly right, and you just heard another word that has no meaning, joint venture, right?

Noreen Vergara I'm sorry.

Meg Pekarske No, no. I think you know everyone says, I want a joint venture, I want a this. It can mean any variety of things. I mean we put some of these things under the heading of a joint venture and stuff. And I think it's, you don't need to know which bucket you want to be in. That's where your lawyer can help you with. It's more like, what do you want to do? And then we figure out sort of what bucket that is.

Noreen Vergara Where you fit. What bucket works for you.

Meg Pekarske So just because you listen to this podcast and are now still like, I'm not sure what bucket I'm in? That doesn't mean anything because that's something we can figure out and we can help you implement if you have the idea. So anyway, well this has been a wonderful conversation and I think.

Noreen Vergara Thanks for having me.

Meg Pekarske Thanks also to our listeners. And I think we're going to be doing additional episodes on value-based care, and Andrew Brenton on our team is and you are going to come back and we're going to talk about this undefined non-hospice palliative care. What are some of opportunities there? Both with Medicare and non-Medicare providers and payers. That will be a great conversation as well. So thanks for making the time and great to talk with you.

Noreen Vergara Good to talk with you. Thanks for having me. This was fun.

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