Lessons Learned from Payer-Provider Partnerships for Community-Based Palliative Care

Despite evidence of the benefits of community-based palliative care (CBPC) and data indicating that our current capacity is insufficient to meet the need, growth of these services has likely been slowed by the lack of adequate, defined funding streams. To address this challenge, from 2014 to 2017, the California Health Care Foundation (CHCF) supported a planning and implementation process for six teams of payer and provider organizations committed to strengthening and spreading CBPC services in California. Participating providers included large academic medical centers, hospices, and a specialty palliative care practice, while the payers included national insurers, regional insurers, and a Medicaid managed care plan.

Payer-provider teams participated in a six-month planning process during which they developed operational and financial plans for delivering palliative care services in community settings (clinics, patient homes, and tele-visits), followed by a 24-month implementation phase where contracts were executed and services were launched. This kind of collaboration between payers and providers is an

emerging trend in CBPC, and our grantees were among the first to participate in such efforts.

In this series, lessons learned from the initiative that address the process of developing and enacting an agreement to deliver CBPC are reviewed. Data sources include semistructured interviews conducted with 13 people who participated in the initiative, progress reports submitted to CHCF by participating teams, and discussions that occurred in grantee meetings and webinars.

Growth of community-based palliative care services has likely been slowed by the lack of adequate, defined funding streams.

Issue Brief

The lessons are organized into eight topics:

1. **Initial engagement,** including useful information to gather from potential partners

2. **Defining the eligible population,** including how eligibility criteria and environmental factors might impact the staffing model, focus, and cost of providing CBPC

3. **Promoting appropriate referrals,** including strategies that payers and providers might use

4. **Service design and operational issues,** such as the need to be transparent about expectations and to develop detailed plans that describe both the care model and the administrative processes

5. **Payment issues,** including different payment mechanisms used by participants

6. **Metrics and assessing impact,** including a list of the metrics used by the participating teams

7. **Monitoring and modifications,** including issues related to transitioning from a pilot to a sustained program

8. **Relationship issues,** including participant observations regarding behaviors that were highly valued and behaviors that created tension

> ▶ **LEARN MORE**
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> **www.chcf.org/payer-provider-lessons**

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About the Foundation
The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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Initial Engagement

Invest in the beginning. Payers and providers that wish to partner to offer palliative care services should take the time to communicate openly and share information about organizational characteristics, goals, and priorities. This helps partners assess if their match will be successful and lays the groundwork for trusting relationships built on flexibility and collaboration.

1 Take the time to create a strong foundation.

➤ The planning period requires an investment of time — and is best accomplished with as much face-to-face interaction as possible to develop relationships and avoid misunderstandings. Phone meetings, especially when many individuals will be participating, may not be the ideal forum for voicing concerns; conversely, in-person design sessions allow participants to pick up on others' cues and to develop trust. However, phone meetings are often the most feasible, and frequent contact is better than infrequent contact.

➤ The initial planning process is typically overseen by a core group that has primary responsibility for exploring the potential partnership. This group then collaborates with colleagues from key operational units (e.g., contracting, finance, informatics, clinical, and operational stakeholders) who can anticipate and address problems early on. Involving individuals from multiple areas of each organization also creates internal champions and experts — individuals who are familiar with the proposed palliative care service who can step in to address issues that arise after contracts are implemented.

2 Start at the beginning — ask questions and don't assume.

➤ Make sure there is a common understanding of what palliative care is, why each organization wants to pursue this type of partnership, what each partner wants to achieve, what success would look like, what outcomes the partners are looking for, and what priorities and pressures are guiding their choices.

➤ Explore the nature of the relationships that the health plan and the palliative care provider have with community physicians and other providers who will provide referrals to the program. Do trusting relationships already exist, or will education and relationship building need to be an early core focus? Have these groups collaborated successfully in the past on quality improvement efforts, or have past efforts created reluctance to engage? Suspicious or burned-out primary care or specialty providers could present a referral barrier that will have to be addressed as part of the partnership.

3 Be prepared to gather and share information to assess the viability and scope of a partnership.

➤ **Geographic service area.** Where will patients come from, and where is the provider willing to go to deliver home-based services? What are the characteristics of the environment (e.g., rural, urban, mixed) and how might that affect service provision (e.g., travel time, general availability of health care services, etc.)?

➤ **Targeted health plan product lines.** Which specific health plan product lines will be included in the agreement? Who holds financial risk for patients covered by these products?

➤ **Patient population profile and volume.** Given the targeted health plan products and likely referral sources, what are the expected population characteristics (e.g., average age, socioeconomic status, clinical complexity)? What are realistic estimates of volume? How many patients would quality for services, how many will likely be referred, and how many would actually accept services? What are current costs and health care service use of these patients?

➤ **Palliative care experience and capacity.** What experience does the provider have delivering community-based palliative care (CBPC) services? What is its capacity to take on new patients? Would new staff be

needed? If so, what is the recruitment or training plan? Does the health plan have experience with specialty palliative care contracting?

➤ **Care model.** How is the provider's program currently staffed, what is the care model, and what services are provided? Does the provider have existing relationships with referring providers? How will each partner work to maximize referrals and patient acceptance of referrals? What are the payer's expectations regarding service levels (e.g., visit frequency by provider type) or modality (e.g., in person or televisit)?

➤ **Infrastructure and resources.** What resources can the health plan provide both behind the scenes (e.g., data mining to identify potential patients, expedited service authorizations, streamlined payment processing) and in direct patient care (e.g., case managers)? If the provider needs to increase staffing to accommodate expected volume, is the payer willing to offer start-up support to help cover losses in the period before referral volumes catch up to staffing costs? Are there existing programs within the health plan that will be improved, challenged, or duplicated by the proposed palliative care program? How will the services be billed for and paid for?

Gathering and Sharing Information

Information that providers should collect from payer partners:

➤ Geographic catchment area

➤ Number and characteristics of target population

➤ Expected number of visits and types of services

➤ Administrative and care management resources available to support CBPC

➤ Who holds financial risk for target population

➤ Cost and health care service use patterns of eligible patients

➤ Experience contracting for CBPC

Information that payers should collect from provider partners:

➤ Geographic catchment area

➤ Status of relationships with current and potential referring providers

➤ Experience providing CBPC

➤ Current CBPC staffing and care model

➤ Information on program processes and outcomes

➤ Capacity to take on new patients

4 **Anticipate complexity and create capacity to modify agreements over time.**

➤ The planning period needs to address clinical, financial, and operational issues, including defining workflows, billing and payment processes, and how problems will be addressed in real time. This complexity is amplified by the number of people at the payer and provider organizations that need to be involved — for example, to develop a contract that spans multiple health plan product lines. Clear communication is key. It will almost certainly take longer than expected to go from concept/intention to implemented contract.

➤ During the planning period, payers and providers should get specific about program parameters (e.g., eligible patient population) and workflow processes and operational issues (e.g., the exact steps for approving patient eligibility, the process for paying providers). Still, there's no such thing as a perfect contract — changes will be needed, so flexibility to revise (or end) the contract needs to be built in up front. Rather than thinking of this as an occasional contract renegotiation, it may be more helpful to go into the agreement anticipating ongoing negotiation and adaptation.

TOOLS AND RESOURCES

Improving Care for People with Serious Illness Through Innovative Payer-Provider Partnerships is a free resource developed by the Center to Advance Palliative Care and the National Business Group on Health. The document includes a review of palliative care delivery models, essential features of successful palliative care programs, and a "Getting Started" checklist.

Defining the Eligible Population

The "who" drives the "what" and the "how." The clinical, operational, and social criteria used to define the target population will influence the number of potentially eligible patients, the number that accept services, and the types of support that need to be provided.

1 **Be intentional in defining the target population.**

➤ Eligibility criteria may include qualifying (or disqualifying) diagnoses, disease-specific clinical markers, estimated life expectancy, functional needs, or health care use history. Particular attention must be paid to feasibility of including patients with substance use disorder or severe mental illness without additional eligibility criteria. Some programs also specify social criteria, such as a safe home environment or patient/family willingness to participate in advance care planning.

➤ Some services have very detailed and extensive criteria, but others do not. There are risks to having very specific or extensive criteria, notably that health plan employees, referring providers, or palliative care providers may have to invest significant effort in verifying eligibility. Very specific criteria can also mean that only a small number of patients will qualify for services. Conversely, very loose or inclusive criteria might identify patients who could be appropriately served by a less intensive program, such as primary palliative care or complex case management. Furthermore, higher-need patients without underlying serious illness (e.g., primarily substance use or psychosocial issues that preclude safe and productive management at home) may outstrip the palliative care team's skills and capacity.

➤ Consider what other programs are available to serve patients with complex needs through the payer or the palliative care provider, or in the local community. The palliative care program may have a valuable role to play for these patients, but payer-provider partners need to be on the same page about whether the program is aimed at people with specific palliative care needs (e.g., pain and symptom management, goals of care, possible transition to hospice) or if it is aimed more broadly at a complex chronic illness or advanced illness population.

➤ Programs that include the complex chronic illness population should tap into existing health plan resources to assist with behavioral health and substance use treatment needs. This population's needs should not be solely managed by the palliative care provider.

2 **Be clear about the pool of patients you will draw from — and the resulting implications for volume, service needs, and costs.**

➤ Operational eligibility criteria may include the specific health plan products, or the care settings from which patients can be referred. These criteria can have a big impact on the number of eligible patients and the characteristics of the population (average age, socioeconomic status) as well as acuity. For example, some health plan products tend to have a relatively younger population that could be more inclined toward pursuing aggressive treatment, or a population with relatively lower socioeconomic status that may have more needs related to housing stability and complex psychosocial issues. If most referrals are expected to come from an inpatient setting, patients are likely to be sicker and have greater clinical needs than a general palliative care population (especially if the inpatient setting is an academic tertiary care center).

➤ Some palliative care providers may choose to offer services only to people covered under their health plan contract(s), while others see their mission as providing care for an entire community, regardless of their connection to a source of payment. In the context of a broad community mission, providers need to pay close attention to balancing their patient mix to ensure organizational financial stability.

3 **Consider how you will determine whether a patient is the right fit in real life, not just on paper.**

➤ Even if a patient appears to be eligible for palliative care, personal or social criteria also determine whether or not they would benefit from or be suitable for a palliative care program.

➤ Social criteria may include patient and family preferences about receiving care in the home and/or via phone or video visits rather than defaulting to a trip to the emergency department, their willingness to engage with the palliative care team in discussing goals of care, their access to the support they need to continue to safely live at home, and having a living environment that a home-based palliative care team feels is safe for them to visit.

➤ A holistic assessment done either by health plan staff or the palliative care provider is typically needed to determine if a patient is eligible for and would benefit from enrollment in the palliative care program. In most cases claims information, authorization records, and data derived from electronic health records can serve as good starting points for identifying patients, but will not be sufficient by themselves.

4 **Understand how decisions about clinical, operational, and social criteria will impact your program.**

➤ Defining who is eligible for palliative care impacts potential patient volume and duration of service (which impacts provider revenue and payer return on investment), care model and staffing (e.g., sicker patients will need more intensive medical management, patients with complex psychosocial issues will require more intensive social work support), and payer and provider costs (who is using what resources to care for these patients).

How Eligibility Criteria Can Impact Volume, Costs, and Outcomes

STRICT CRITERIA CAN . . .	BECAUSE
➤ Increase administrative effort for enrollment	Need to query multiple sources to find evidence of disease status, specific biomarkers, patient preferences, and other social criteria
➤ Increase lag time between referral and enrollment	Time needed to verify eligibility, especially if multiple individuals or data sources need to be queried
➤ Decrease volume	Fewer patients will qualify; some will drop off while waiting for eligibility to be verified
➤ Reduce variation in outcomes	Low variation in key population characteristics will increase confidence in estimates of care delivery costs and expected outcomes

LOOSE CRITERIA CAN . . .	BECAUSE
➤ Reduce administrative effort for enrollment	Less need to find or access data to determine eligibility
➤ Reduce lag time between referral and enrollment	Relatively less time needed to verify eligibility
➤ Increase volume	Higher probability that referred patients will be eligible for services
➤ Increase variation in outcomes	Variation in acuity, service needs, service duration, and risk for use of expensive health care services mean care delivery costs and all types of outcomes will be less predictable

Promoting Appropriate Referrals

Use all your assets. Payer and provider both share responsibility for getting the right patients to the service.

1 **Balance your use of data filters *and* human filters — not just one or the other.**

▶ The patient identification and referral strategy should incorporate both the payer's and the provider's assets and relationships. The strategy should be defined early in the payer-provider relationship with the expectation that it will be revisited over time as challenges arise and as needs, resources, and program volume change.

▶ Some providers want and expect a referral channel from the payer, but not all payers have the robust and flexible information systems needed to access data that could be used to identify appropriate patients.

▶ Health plans can identify potentially eligible patients through data mining based on diagnoses, use of health care services, presence of authorizations for certain drugs or services, and costs. Challenges include the time lags of claims data, inaccurate or missing diagnosis data or contact information, and figuring out the right filters or predictive model to accurately flag the patients most appropriate for palliative care. Providers should not expect perfection from a health plan list — it is a starting point. Alternatively, plans can give lists of potentially eligible patients to primary care and specialty providers, inviting them to consider if any listed patients might benefit from palliative care — and if so, to make direct referrals to palliative care providers.

▶ Health plans can also tap the expertise of their case managers to identify appropriate patients, introduce them to the palliative care service, and inform their primary care provider about the plan to refer them to palliative care.

▶ Referrals should also come from the community's providers — they know the patients best — but this strategy requires ongoing education and significant effort.

▶ Embedded models of palliative care delivery in clinic-based care may allow for efficient and accurate identification of patients.

2 **Ongoing relationship building and education are essential for community providers.**

▶ Marketing and education about your service is not a once-and-done activity. Potential referrers may not have a strong understanding of palliative care, may equate it with hospice, and may resist the idea of other providers getting involved in the care of their patients. This is especially important if provider referrals are the main strategy for identifying and engaging patients. Even if health plan data mining accounts for a significant part of the initial patient identification strategy, the palliative care program needs to maintain open communication with patients' primary providers to support continuity of care.

▶ Both the health plan and the palliative care provider can help educate potential referrers. Some palliative care providers encounter strong resistance when they contact primary care providers about possibly enrolling a patient in palliative care. Having payers actively engage with and educate their medical groups about the palliative care program could go a long way toward breaking down those barriers.

▶ Clinic-based embedded models of palliative care delivery —where palliative care providers and referring providers work closely together — allow for ongoing education and engagement.

▶ Some payers may require evidence of relationships with referring providers as a prerequisite for new contracts with palliative care providers, to ensure that patient volume will meet expectations.

▶ The challenges of engaging referring providers are different for partnerships where the palliative care providers and referring providers work for the same organization (such as a medical group, or all are affiliated with a

health system) versus "external" palliative care providers (e.g., an independent hospice offering nonhospice palliative care services). External providers need to partner with their payers to engage and educate referring provider groups so they understand why another organization would be involved in the care of their patients, especially if patients are identified directly by the health plan through data mining. Cobranded materials describing the service that link the palliative care provider to the health plan can also help potential referring providers feel more comfortable working with external palliative care providers.

3 **Don't underestimate the amount of time this takes; don't overestimate the number of referrals that will result.**

➤ Depending on the process for patient screening, identification, and initial outreach, enrollment can take a significant amount of provider time. This adds to the provider's costs. As payers and providers seek to align their payment model with services delivered, they could consider opportunities to balance these responsibilities and costs between both parties.

➤ If the health plan doesn't have systems to support data mining, palliative care providers need to do continuous education of and relationship building with potential referral sources — including all levels of providers (physicians, nurses, social workers, case managers, etc.).

➤ Verifying eligibility (health plan authorization for enrollment in palliative care) can be time-consuming for the provider. A system should be in place so that authorization for enrollment into palliative programs can happen in a timely manner — health plans can consider flexibility in allowing providers to determine which referred patients need their services.

➤ If the program relies heavily or exclusively on referrals from community providers (without health plan data mining and patient outreach), be conservative in your estimates about how many patients will be referred. While many patients could benefit from palliative care services, changing practice patterns is hard and takes time.

4 **Remember that referrals are just the beginning; initial referral volume may be low and may increase slowly.**

➤ Even if the patient identification and referral strategy is robust, patients and their families need to understand how palliative care can help them, or they may refuse the service. Marketing and communication strategies need to extend past referring providers to patients and families themselves.

➤ Take time to assess whether your data mining and referral processes are identifying the right patients. These processes may need adjustment if patient acuity is unbalanced (e.g., all high-intensity needs and hospice-eligible, or many individuals who do not meet illness stage / life expectancy requirements).

Proactive Approach to Patient Identification

Payer strategies, which generally rely on mining claims or authorization data, should be combined with strategies that rely on referring providers to identify potentially eligible patients. (See "Roles in Promoting Appropriate Referrals" table.) This hybrid approach requires significant effort and coordination, but offers the best chance of identifying the most — and most appropriate — patients.

Roles in Promoting Appropriate Referrals

Payer Strategies

➤ Use claims data to look for eligible patients. *Examples: diagnosis, durable medical equipment, health care service use, costs*

➤ Set up routine intervals for patient identification

➤ Develop workflow for getting information to providers

Provider Strategies

➤ Develop clinical triggers to identify patients. *Examples: new diagnosis, new event*

➤ Routinely review patient panels

➤ Invite palliative care team to participate in case conferences

Service Design and Operational Issues

Specify services and processes, and expect to revisit. The clinical model and operational processes related to patient care impact care quality, patient and family satisfaction, and costs, so thoughtful attention to the details is essential. Even with careful planning, partners will need to solve problems and adjust along the way, so scheduled periods for reassessment and flexibility are key.

1 Align the clinical model with desired outcomes and patient needs.

► Payers and providers should clarify what outcomes they are looking for in writing, and should define the clinical services that are expected to produce those outcomes. Partners need to agree on the staffing model (who, what, where, how, how often) to appropriately consider costs and payment levels. Once a model is settled on, do a reality check — is it reasonable to expect that the specified interventions will lead to the desired outcomes?

► Services will vary based on the population and their unique needs (e.g., pediatric versus adult, rural versus urban, Medicaid versus commercial/Medicare, last year of life versus complex care). Partners should be realistic about how population characteristics impact potential outcomes; for example, length of service and use of health care services may be higher for younger patients, patients with lower socioeconomic status, or those with behavioral health issues.

2 Clarify your expectations and your boundaries.

► Partners should be transparent about their expectations for clinical services to be delivered, and whether the contracted palliative care provider is equipped to deliver those services themselves or if other partners are needed. For example, clarify whether the palliative care team is expected to take over the care of the patient or only act as a consultant. Assess whether the provider has capacity for specific clinical interventions that patients may need (e.g., home-based IV infusion, physical therapy, occupational therapy) or if the payer can bring in other vendors to meet those needs.

► Providers should consider whether they are open to customizing their service model for different payers or whether they want to stick closely to a particular model. Customization may mean more potential payer contracts, but it is likely to be harder to sustain over time due to the need to assemble different provider teams and approaches for different payer sources.

3 Consider approaches that will increase efficiency.

► Investigate how telehealth and video visits could be used to improve efficiency and lower costs. This could include video visits with the physician to complement in-person visits from a nurse or social worker, or partnering with a local community health worker or health plan case manager who travels to the patient's home and facilitates the video connection to the palliative care team.

► Define opportunities for higher-intensity and lower-intensity service models for patients depending on their acuity and needs, with variation in which providers are involved, at what frequency, and in what settings.

► Primary care or specialty providers can be supported (and trained, as needed) to provide generalist palliative care (also called primary or frontline palliative care) to extend the capacity of the specialty palliative care team.

4 Identify pathways to prevent and resolve operational challenges.

► The payer and provider each have separate responsibilities in patient care, and coordinating these roles can be challenging. A common hurdle is securing health plan authorizations — for example, a palliative

care provider may identify a patient's need for in-home oxygen, wound care, or durable medical equipment but may have difficulties securing such services, as the palliative care provider is not the patient's primary provider or a health plan representative.

▶ With each new payer contract, payers and providers need to define administrative and operational processes and clarify roles for getting patients the services they need, when they need them. Processes to streamline or fast-track authorizations can reduce the burden on the palliative care team, which is at risk for spending a lot of time addressing these issues rather than providing their core services. Getting very clear on administrative processes and working to be as efficient as possible can go a long way toward assuring a positive payer-provider partnership and better outcomes. If a patient who needs a medication refill cannot get it, the odds of an emergency department visit go up, and patient satisfaction and quality of life go down.

▶ Some providers may want to take on the responsibility (and financial risk) for certain services — such as durable medical equipment, physical therapy, or home health — because they have well-established and highly functional relationships with vendors.

Key Questions for Service Design, by Desired Goal

Link services to needs and expectations	▶ What support does the population need?
	▶ What problems are the partners looking to solve?
	▶ What are expectations for outcomes and impact?
Define roles and boundaries	▶ What will the palliative care provider do?
	▶ What will the payer do?
	▶ What will other organizations do?
Revisit model and workflows regularly	▶ Are there opportunities to increase efficiency?
	▶ Are any operational processes frustrating either party?
	▶ Are effort and outcomes satisfactory to both parties?

TOOLS AND RESOURCES

23 Factors That Impact the Cost of Delivering Palliative Care, a resource published by the California Health Care Foundation, can help payers and providers appreciate the extent to which their policies, preferences, and practices impact the cost of delivering palliative care.

Payment Issues

Be open and open-minded. Determining the right payment mechanisms and amounts requires that both the payer and provider have a solid and realistic understanding of total care delivery costs. Payers and providers need to be willing to revisit expectations and processes to achieve and maintain alignment between costs and payment level.

1 Understand the actual cost of delivering care: what, who, where, how, how often.

► Providers need a detailed, concrete understanding of what it would cost in the actual practice environment to provide the specific services included in a contract and the extent to which those costs could be modified if certain processes or expectations are adjusted. Developing this information may be a new experience for some providers, particularly organizations that are accustomed to delivering hospice care, which features a standard set of services and payments that are based on a set fee schedule. The specific services to be delivered by a palliative care team tend to vary from contract to contract, so providers and payers need to understand actual care delivery costs and the variables that drive these costs for each contract.

► Cost of care varies depending on the services being delivered and the team members, frequency, and settings in which the services are provided. Each of those elements should reflect an understanding of the target population's needs and the extent to which the palliative care organization is expected to address them. When providers are looking to deliver care to a population they are not familiar with (such as an organization accustomed to delivering care to a Medicare population that is now looking to serve a Medicaid population), special care must be taken. In these situations, costs may be significantly more than initially expected. Theoretically, an unlimited amount of service can be provided to every seriously ill patient. The challenge is to determine the right amount of service needed to achieve the desired outcomes, given available resources. If the proposed payment amount is significantly lower than the computed cost of care delivery, the care model (who does what, how often, via in-person or phone or video interventions) will need to be adjusted.

► If a bundled payment approach is being considered (a fixed payment intended to cover the provision of all palliative care services over a specified time period), providers and payers need to estimate how much of which types of service are likely to be delivered in the payment period. For example, typical services to be delivered to each patient per month may include one registered nurse home visit, one social worker visit, one video visit by a physician, two phone contacts by the social worker, and one phone contact by the chaplain. The cost of each of these encounters should be estimated and combined to determine average total cost of care per month. It is important to account for the cost of traditionally unbillable encounters (care delivered by chaplains, for example), as well as environmental variables that impact cost of care delivery (for instance, drive time to patient homes in a rural area). Estimates should address the full cost of providing services, including administrative and clinical infrastructure costs (e.g., costs associated with data collection and quality monitoring, patient identification and engagement, and interactions with referring providers).

► The psychosocial support services included in a palliative care bundled payment should be clearly delineated. It may make sense to exclude services provided by psychiatrists and psychologists from the bundle (since payment mechanisms for these providers exist) but to include supports offered by palliative care team social workers or chaplains, which are not usually billable.

► Palliative care providers should account for cost differences expected during the start-up phase of a new contract, which can differ from expected costs when the program is functioning and operating at optimal capacity. It usually takes time for program referrals to ramp up, so the cost per patient is likely to be higher when programs are new and volumes are low, as indirect costs need to

be covered by a smaller number of revenue-generating patients. Further, when programs are just starting out, clinical care teams might be less efficient generally and will likely spend more time engaged in outreach and education with providers rather than in patient care. Organizations that are adding a new contract to a mix of existing and profitable palliative care contracts will find it easier to absorb start-up losses than organizations that are entirely new to providing palliative care.

▶ Providers should estimate the patient volume needed to achieve financial breakeven. This break-even calculation can focus on the volume needed to make a specific contract viable and could be extended to the provider organization's overall payer mix. For example, some organizations will need to take into account the cost of providing palliative care to individuals for whom there is no payment source. While the organization may see providing "charity" care as being part of a larger mission, it is not appropriate to expect that payer partners cover the cost of that care.

2 Anticipate negotiation, renegotiation, and adjustments over time.

▶ Payers and providers should come to the negotiating table with open minds about the payment model, payment amount, and service delivery approach. Partners need to work through the numbers and options together — providers should be transparent and thorough in detailing their costs and should be open to opportunities to make their service delivery more efficient, while payers should be open to revisiting their assumptions about what it takes (in terms of services and dollars) to provide high-quality palliative care. This type of working collaboration may be a new practice for the provider organization, the payer group, or both.

▶ On a regular basis (e.g., annually, perhaps more frequently initially), providers and payers should examine data on service provision and outcomes to determine if adjustments to the care model, payment model, or payment amount are warranted.

▶ Problems can arise when either party enters negotiations with a predetermined payment amount or care delivery model in mind. Things tend to progress more smoothly when the two parties develop a shared understanding of actual costs, and then adjust expectations related to care model and payment amount accordingly.

▶ Both the plan and provider have options for changing processes to better balance payment and effort. Plans can explore options to increase payments in certain circumstances or can consider using plan staff to perform some services (e.g., case management, eligibility screening). Partners can consider adjustments that would make more efficient use of resources (e.g., approaches to reducing provider drive time and documentation time, or ensuring that all care team members are working at the top of their license). While adjustments to the care model are often possible, significantly changing the amount or type of care being delivered may have a negative impact on outcomes.

▶ Payers and providers should carefully consider contractual requirements that dictate minimum visit frequencies from specific disciplines by specific means (e.g., requiring two nurse home visits per month). Such arrangements can create confidence in the amount and type of services being delivered, which some may equate with care quality and adequacy. On the other hand, being too specific can eliminate provider options for increasing efficiency by titrating services to meet patient needs, and forces the use of one member of the clinical team (such as a nurse) when the patient might be much better served by increased support from another team member (social worker or chaplain, for example).

3 Consider a layered approach.

▶ Within the California Health Care Foundation (CHCF) payer-provider partnership cohort, the most common payment model was a "case rate" or "per enrolled member, per month" approach, sometimes augmented by other payments designed to incentivize certain behaviors or compensate providers for services that exceed contract expectations. Layering payment mechanisms can reduce providers' risk and can help align incentives. (See "Payment Mechanisms Used" table on the following page.)

▶ Small provider organizations and those new to providing palliative care to a specific population should think carefully about the benefits and hazards of sharing financial risk. While risk sharing can align incentives, just a few

Payment Mechanisms Used by the CHCF Payer-Provider Partnership Teams

Case rate or per enrolled member, per month payment	Payments made on monthly or biweekly basis, often with different rates depending on patient location (private residence or nursing facility), that cover a bundle of services provided by the interdisciplinary palliative care team
Supplemental payment for patients using more services	Payments made above case rate for patients who require significantly more support than expected, often driven by psychosocial issues that complicate the delivery of palliative services
Assessment or engagement fee	Separate payment to cover the cost of doing a comprehensive initial assessment and for provider effort before patients are enrolled in the program, and to create a revenue source in instances where the patient is found to not meet the contract's eligibility criteria
Quality incentive	Payment for meeting particular quality criteria — for example, no trip to emergency department or unplanned admission to acute care hospital in a specific period of time
Data collection and reporting incentive	Payment for gathering and submitting specified data elements related to patient characteristics, care processes, or outcomes, beyond items that the provider would document routinely to support care delivery
Advance care planning incentive	Linked to conducting and documenting discussion of patient preferences, with or without completion of formal advance directive or POLST (Physician Orders for Life-Sustaining Treatment) form

outlier cases can impact revenues significantly in a small patient population. Successful risk sharing requires that both parties be willing to share financial data, and provider organizations need to be able to wait for some payments (for example, it takes time to determine if savings were achieved, so shared savings payments come with a delay). In some circumstances, risk-sharing agreements might require the partners to engage an independent party to calculate outcomes and apportion shared savings or responsibility for losses.

4 Financial negotiations can be tough.

► It's no surprise that it can be difficult to talk about money — and that payers and providers may come to discussions about payment with their defenses up. But if either partner is unhappy with the payment model or amount, resentment can build if the issue goes unaddressed, threatening the sustainability of the partnership. Payers and providers need to be willing to engage with each other in potentially difficult conversations.

► Frustration can arise if one party is perceived to be less open or flexible than the other. Even in circumstances where there is disagreement on payment amount, partners tend to be more satisfied if both parties are perceived by the other to be consistent and transparent. Without this, relationships are likely to deteriorate.

► Among the CHCF payer-provider partnership teams, some providers thought they would not be able to sustain their services at the funding levels of their original contracts, and some perceived health plans to be accruing savings that would have justified larger payments. Some health plans noted that their actuarial practices did not allow for payment for anticipated savings — they needed to demonstrate the savings first, and then consider increases in payment. This dynamic can create something of a stalemate where the providers cannot see enough patients to generate credible evidence of savings in part

because they cannot afford to incur the losses that would accompany the needed increase in volume. Securing funds to cover start-up costs and expected losses can mitigate this difficulty, as can strategies such as carrying out intensive efforts to increase referral volume relatively rapidly and paying separately for some services (such as initial comprehensive assessments) that require significant provider work. The best protection against an unsustainable contract is a careful assessment of the actual cost of care delivery before the agreement is signed, followed by regular reassessments. Providers should be realistic about their organization's ability to weather losses if volume is lower than expected or costs are higher than expected.

TOOLS AND RESOURCES

The Center to Advance Palliative Care's *Payment Primer: What to Know About Payment for Palliative Care Delivery* describes different ways health care is paid for and key concepts that impact payer-provider payment relationships. CHCF's *Five Ways to Pay: Palliative Care Payment Options for Plans and Providers* describes five payment models that can be used to support palliative care delivery, plus considerations for health plans and providers related to each of these models.

Two more CHCF resources, the *Decision Points Worksheet* and *23 Factors That Impact the Cost of Delivering Palliative Care*, can help payers and providers identify variables that impact the cost of care delivery and devise strategies for increasing efficiency.

Metrics and Assessing Impact

The right way is the way that works for both parties. There is no universally accepted or feasible set of metrics that is required for or used by all community-based palliative care (CBPC) programs. The right metrics are the ones that are feasible to implement and that meet the information and decisionmaking needs of both the plan and the provider organization.

1 **Expect variation in reporting requirements and metrics across contracts.**

▶ The data-reporting requirements and metrics used by the six California Health Care Foundation payer-provider partnership teams varied significantly. Some plans required no data reporting at all, others had extensive requirements, and some providers routinely collected additional information beyond required elements to support internal quality-assessment activities.

▶ Most partnerships monitored the amount of service delivered, where it was delivered, and by whom; key care processes; patient, family, and caregiver experiences; and use of health care services and fiscal outcomes, with wide variation in specific metrics used across contracts.

Sample Metrics Used by Payer-Provider Partnership Teams

Operational

▶ Number of patients referred, percentage with scheduled visits, percentage visited

▶ Average number (and range) of:
  ▶ Visits per patient in enrollment period
  ▶ Days from referral to initial visit

▶ Average number (and range) of days between visits

▶ Percentage of patients seen within 14 days of referral

▶ Referral sources

▶ Referral reasons

▶ Use of telehealth/video visits

Screening and Assessments

▶ Percentage for which:
  ▶ Spiritual assessment is completed
  ▶ Functional assessment is completed

▶ Symptom burden measured by standardized instrument, at initial visit and at follow-ups

▶ Patient distress measured by standardized instrument, at initial visit and at follow-ups

▶ Percentage for which medication reconciliation is done with 72 hours of hospital discharge

Planning and Preferences

▶ Proportion of patients with advance care planning discussed

▶ Percentage of patients with advance directive or POLST (Physician Orders for Life-Sustaining Treatment) completed

Hospice and End-of-Life Care

▶ Percentage remaining on service through end of life

▶ Percentage dying within one year of enrollment

▶ Percentage enrolled in hospice at the time of death

▶ Average/median hospice length of service

▶ Location of death

▶ Percentage dying in preferred location

Service Use and Fiscal Outcome

▶ Per member, per month cost of care, enrolled patients versus comparison population

▶ Health care use/costs 6 to 12 months prior to enrollment compared to 6 to 12 months during/after enrollment:
  ▶ Number of acute care admissions
  ▶ Number of (total) hospital days
  ▶ Number of intensive care unit (ICU) admissions
  ▶ Number of ICU days
  ▶ Number of emergency room visits
  ▶ Total cost per member/patient

2 Consider feasibility — data access and data collection burden.

➤ Assessing process and outcome metrics is essential for plans to demonstrate return on investment, and for providers to demonstrate the value of their services and identify quality gaps. However, data collection and reporting can require significant resource investment. In general, a shorter list of items that can be assessed well is better than a very long list of items that may be cumbersome to implement or may be hard to collect with accuracy. Partners should avoid situations where clinical staff must choose between dedicating time to patient care or dedicating time to mandatory data collection. Partners should set reasonable benchmarks, knowing that optimal care delivery and outcomes will vary across the patient population. For example, a metric describing the proportion of individuals who die at home would need to account for the fact that dying at home is not a viable or preferred option for all patients.

➤ Plans and providers should approach metrics selection thoughtfully and be prepared to negotiate on the items to be collected, the reporting format, and the reporting frequency. Each party should be clear on what data they are able to collect and their capacity to monitor specific quality metrics, and contracts should specify which party carries responsibility for each selected metric (who gathers the data, who analyzes the data, who reports the data, which data/outcomes are shared between the parties, with what frequency).

➤ Some plans have extensive measurement and reporting requirements that can be onerous for smaller provider organizations to execute. This results in time-consuming manual data collection and tracking, which is difficult to sustain over the long term.

➤ Providers with multiple contracts find that variation in required metrics threatens sustainable data collection and outcomes measurement. For such organizations, a starting point in developing an evaluation plan for a new contract should be the metrics they already collect and report for other contracts.

3 Share the burden and prepare for the long haul.

➤ Both parties can expect to contribute some data and carry some of the burden of data collection, aggregation, and analysis.

➤ While some metrics used early in a payer-provider partnership may be discontinued over time, many requirements are likely to be maintained, especially those used to assess impact on fiscal and health care service use outcomes. Partners should expect to revisit evaluation plans and reporting requirements intermittently but should not be surprised if only minimal adjustments are made.

➤ Plans requiring extensive data reporting can soften the burden on provider partners by using plan staff to aggregate and analyze the raw data that providers collect, by offering incentive payments for submitting data, or by adjusting case rate payments to reflect the added effort required to collect data that is beyond what is needed to provide clinical care. Some plans have supported data collection and a focus on quality by covering membership fees for contracted providers wishing to join quality and benchmarking organizations, such as the Palliative Care Quality Network (PCQN) or the Global Palliative Care Quality Alliance.

➤ Membership in palliative care quality/benchmarking organizations can also help both partners interpret their own outcomes. This is especially useful if the population being served is somewhat different than the populations most commonly studied in published reports (e.g., care is being delivered to a Medicaid population, which is notably younger and more complex than the populations featured in the palliative care literature.)

TOOLS AND RESOURCES

Programs or partnerships that are developing a metrics plan might consider items included in Measuring What Matters, a set of performance measures recommended by the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association.

A broader set of possible metrics is included in the Palliative Care Measure Menu, which allows users to select palliative care metrics based on focus area, required data, and other criteria.

Programs looking for benchmarking opportunities might consider the PCQN, a continuous learning collaborative that features a patient-level registry and a common set of metrics for both inpatient and community-based palliative care services.

Monitoring and Modifications

The contract is just the beginning. Achieving and sustaining balance across three critical areas — cost of care delivery, payment amount, and desired outcomes — requires ongoing attention to how the program is functioning and a willingness to revisit multiple aspects of program design and operations.

1 **Monitor and modify to ensure balance across effort, payments, and outcomes.**

▶ Provider effort should be aligned with payment amount, and plans need the delivered palliative services to result in improved outcomes. If there is sustained imbalance across effort, payment, and outcomes, then the partnership is at risk.

▶ Even if balance was attained during the early stages of a partnership, it can be threatened or lost as the program grows or circumstances change.

▶ It's important for partners to speak up if they suspect or experience imbalance. Successful partnerships have processes in place to identify issues sooner rather than later.

▶ There are multiple strategies for modifying clinical and administrative aspects of the contract that can support better balance across effort, payments, and outcomes.

Possible focus areas related to reducing provider effort and cost of care delivery:

▶ **Scope of service.** Is the palliative care team providing supports or services that could be covered by a different team with a separate funding stream (e.g., health plan case management, home health, behavioral health, social services)? Is the scope simply broader than what can be covered by available payment?

▶ **Care model.** Does the contract call for specific amounts of service to be supplied by specific disciplines? If yes, can these requirements be adjusted while still providing enough service to support good outcomes? Can some services be delivered via phone or video visits? Could some services be provided by different team members — for example, using a community health worker to cover some tasks under the supervision of the team social worker? In general, does the team feel that the frequency of visits is on target?

▶ **Appropriate use of specific disciplines.** Are all members of the care team operating at the top of their license? Can some tasks be delegated to administrative or clinical staff with relatively lower salaries or more availability?

▶ **Reducing time required for work that doesn't generate revenue.** Are team members investing significant time in assessing initial or ongoing eligibility? If so, can criteria be simplified, or can the plan take responsibility for some of this work? Are there opportunities for reducing effort invested in data collection, securing authorizations, or other administrative processes? Is time spent in meetings appropriate, both for internal meetings and meetings with external organizations, such as payer partners? Can some meetings that have been held in person be shifted to a phone or video platform, or could they be held less frequently?

Possible focus areas related to plan payment amount and provider revenues:

▶ **Low volume (inadequate total revenues).** Is it possible to revisit the eligibility criteria? Complex criteria may discourage referrals over time (if multiple referred patients are deemed to be ineligible), confuse referring providers, or identify fewer eligible patients than had been expected. Volumes that are lower than expected mean unexpectedly lower revenues for providers, a circumstance that can be especially difficult for provider organizations that hired staff in anticipation of a certain number of referrals from a new payer partner.

- **Carve-outs.** Can some services be carved out of the case rate? Initial assessments are typically an appropriate target for separate payment, as care teams will often conduct assessments for patients who do not qualify for the palliative care service, or who opt for immediate hospice enrollment.

- **Supplemental payments.** Can supplemental payments be considered for specific circumstances or services? Common examples are payments to cover outlier cases (patient requires significantly more than the expected amount of service, often due to psychosocial issues) or payments to cover the cost of data collection if plan reporting requirements are extensive or require manual data collection or extraction.

- **Incentive payments.** Can the contract be modified to include incentive payments related to data reporting, discussion, or documentation of patient and family preferences, or the absence of unplanned hospital admissions?

- **Sufficiency assessment.** It could be that, given the agreed upon scope of services, the initial payment amount underestimated the cost of care delivery. If all strategies for improving care delivery efficiency and reducing costs have been tried, the conclusion may be that the contract needs to be renegotiated (i.e., the payment amount needs to be increased) to cover that scope of services for that patient population in that region.

Possible focus areas related to outcomes:

- **Care model.** If outcomes are not as positive as expected, partners may review the care model to determine if the right amount of service is being delivered by the right disciplines and in the right doses.

- **Staff training.** Partners may need to assess the clinical competence of staff. Have providers completed appropriate training? Has the provider organization experienced turnover, and do new staff need more training, mentoring, or proctoring to deliver quality care?

- **Target population.** Relatively inclusive eligibility criteria may identify patients whose needs could be better served by less intensive support programs, such as complex case management.

- **Timing of referrals.** If patients are being referred very late in the course of illness — in the final 30 to 60 days of life, for example — it is quite likely that the palliative care team does not have enough time to impact outcomes. Partners may wish to focus on strategies for promoting earlier referrals of appropriate patients.

- **Adjusting expectations.** Partners may wish to assess the extent to which their expectations were realistic. Given the population being served and the services being delivered, are more impressive outcomes possible? Are factors that are beyond the palliative care provider's control contributing to high costs? Organizations that belong to quality collaboratives, like the Palliative Care Quality Network, are in a better position to benchmark performance and interpret outcomes.

2 **Expect new challenges as a program transitions into a sustained, growing service.**

- Initially, it can be helpful to approach a new partnership as a pilot, where parties commit to a trial of the new contract and expect to make minor adjustments along the way and major adjustments at the close of the pilot period (after assessing costs and other outcomes). Pilots are often characterized by on-the-fly adjustments based on real-time learning. One California Health Care Foundation (CHCF) payer-provider partnership participant noted, "What you think you know at the beginning has to be adapted as you learn along the way — it's a dynamic process." In such an environment, success depends on both parties being attentive and flexible.

- Transitioning from pilot to sustained service often requires revisiting nearly every aspect of the program. Scope of services, eligibility criteria, strategies for promoting referrals, payment amounts, metrics, and expected outcomes all need to be reexamined and potentially adjusted. While the pilot may have emphasized experimentation and learning, sustained programs are characterized by standardization, automated processes, and predictability. Operations that were very hands-on and manual need to be systematized. It is possible to maintain intensive focus on supporting a new service for a pilot period, but eventually the contracted service needs to function without extensive administrative attention from either the payer or provider.

➤ Not every partnership can successfully transition from pilot to sustained program. After looking at financial outcomes, a payer may want a provider to do the same amount of work for a lower payment, which may not be acceptable to the provider. A provider may decide that a plan's data-reporting requirements or administrative processes are too cumbersome and opt to not continue the relationship. If continuing the partnership is not a possibility, it is best to exit the relationship with grace, to preserve the option of future collaboration if circumstances change. Payers and providers could both learn from a failed partnership what is necessary for their success in subsequent partnerships.

TOOLS AND RESOURCES

The *Decision Points Worksheet* is a resource published by CHCF that explores multiple variables that can influence the cost of care delivery, as well as options for changing clinical and administrative processes that could help payer-provider teams reduce costs while maintaining quality.

Relationship Issues

Creating a mutually satisfying and beneficial contract is hard, but a good payer-provider relationship makes it a lot easier. Partners need to be willing to communicate openly and frequently about all aspects of program planning and implementation. Partners need to build trust, understand why they each want to engage in this work, and show an appreciation for the pressures and priorities that impact the other organization.

1 Listening, transparency, empathy, and collaborative problem solving are highly valued.

▶ Many California Health Care Foundation payer-provider partnership participants noted the importance of having a partner who approaches contracting with a spirit of collaborative problem solving. Successful partnerships developed a shared expectation that "things won't run perfectly" and that the parties needed to collaborate to find solutions. Participants viewed flexibility and accessibility as essential, especially once services launched. Providers emphasized the need to have rapid access to their payer counterparts to iron out clinical and operational issues impacting care delivery, such as difficulties accessing medications, supplies, or services for their patients.

▶ "Flexibility," "creativity," and a "can-do attitude" were identified as characteristics and abilities essential to a successful relationship. Participants valued partners who showed openness to being innovative and possessed an accompanying commitment to navigating the problems that surface when something new is piloted. The extent to which the payer-provider relationship was grounded in trust and flexibility was noted as a predictor of success.

▶ Problem solving in the setting of a new service requires all parties to be alert to unexpected events and challenges, and to be on top of the details and critical processes that need to be completed to move a project forward. Consistent follow-up on action items was a valued quality for individuals and organizations.

▶ Participants noted the importance of maintaining open communication and a willingness to work together to address differences in expectations. As one participant noted, "Don't beat around the bush when there's a concern; it is essential to communicate (ideally in person) about a problem. This stuff is too important to not be direct."

▶ Creating a contract and launching a new service are tough tasks, so a positive outlook was valued. Participants noted the importance of having a spirit of "we're going to make this work" and determination to "not let difficulties squash the team's spirit."

▶ While recognizing that both sides of the partnership are aligned with a mission to care for seriously ill patients, both parties need to convey empathy for, or at least knowledge of, the priorities and pressures that impact the other party. This can require avoiding or letting go of an "us versus them" mentality — which can be difficult if parties disagree on core contract components, especially payment amounts.

2 Organizational culture influences relationships.

▶ Differences in the size and corporate culture of payer and provider organizations are likely to impact relationships. Many aspects of how individuals function within the payer-provider partnership will be dictated by organizational culture, and partners should be aware of how these cultural differences impact the way they work together.

▶ Smaller provider organizations are usually able to implement changes or reach decisions relatively quickly. Larger organizations, whether payers or providers, tend to have complex processes where approvals must be sought through standardized (and potentially multistep and rigid) processes. Larger organizations are also more likely to be somewhat diffuse; it can be harder to figure out who needs to be involved in any given decision, and it can take time for a decision to be made

or for a change to be implemented. When assessing the quality of the relationship, it can be useful to distinguish circumstances or situations that are the result of individual behaviors from circumstances or results that are the product of the larger organizational culture.

3 It takes time to build relationships.

▶ Partners need time to build trust in one another, to understand why they each want to engage in this work, and to be open about the impact of different approaches to care delivery, data collection, payment amounts, and other key processes. As one participant put it, "It is a process, not an event. . . . We're still working things out after two and a half years."

▶ Both payers and providers that found new partners during the project period noted that they had to repeat the relationship-building process — the early process steps could not be skipped, even if both parties had some experience contracting to deliver palliative care. As a participant noted, "Just because you are more knowledgeable . . . doesn't necessarily mean you can go (a lot) quicker when contracting with new partners. . . . There is a relationship, contract-building process that . . . has to happen — you can't skip that part."

What are the most important characteristics you look for in a potential community-based palliative care partner?

PROVIDERS

"Willingness to invest time in relationship building, getting to know each other as people."

"That they are collaborative and flexible, able to appreciate the perspective of a small partner."

PAYERS

"Ideal partner characteristics would be an ability to take in information from many perspectives (vision and mission plus practical information about service delivery nuts and bolts, and the environment), including an ability to appreciate the perspective of a payer partner."

"Relationships that care teams have in service areas are key; if they have them in place they can hit the ground running; otherwise, they are likely to struggle."

What are characteristics that might be predictors of a poor fit?

PROVIDERS

"As we brought issues to the forefront (big and small) the plan was always willing to engage in a conversation — to hear from our perspective how a contract requirement would impact care. Even if the plan didn't agree, it was important to us that they were willing to have that collaborative conversation. Not seeing this kind of openness would be a huge red flag; a payer that just says, 'This is the way we do it' would be a difficult partner."

"Rigid, no appreciation of provider side, poor understanding of palliative care principles and target patients."

PAYERS

"I try to get a sense during early meetings whether they are comfortable taking risks, if they have demonstrated an ability to think differently, and if they have a record of implementing innovations. An absence of such characteristics, history, or a rigid attachment to their own model of care delivery would indicate a poor fit."