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.

This paper is part of a series on payer-provider partnerships in palliative care. To read the rest of the lessons, visit www.chcf.org/payer-provider-lessons.