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.

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.