California Health Care Foundation

Decision Points Worksheet

Let's say a payer and provider partnership has designed a palliative care (PC) service that meets SB 1004 requirements. The team has carefully estimated the cost of offering the specified services, including direct care, to the designated population. The payer offers a per-patient-per-month amount that is considerably less than the estimated cost of care delivery. While negotiating for a higher rate may be an important component of a solution, the two organizations decide to first explore opportunities to change some care delivery and administrative aspects of the program to reduce projected costs while maintaining quality. This table summarizes some of the change options or "decision points" that could be reconsidered.

*Review the **Factors, Implications,** and **Options** presented in each row. Do any pertain to your existing or planned program? Use the open space within each row to enter notes on other Options that you might consider. Use the blank rows to note other Factors, Implications, and Options pertinent to each program design topic (Population, Scope of Services, Care Model, Communication/Coordination, Engaging Patients/Referring Providers, and Operational Issues).*

Factor or circumstance	Implications: what this may mean for the provider organization and cost of care delivery	Options / solutions
POPULATION		
Target population is complex: mental health issues, poverty, substance use disorder, late presentation with advanced illness, etc.	• Intense case management needed • Broad set of services required • Social and practical issues may complicate or override areas PC team usually focuses on; PC team may invest significant effort in tending to those social and practical issues	• Collaborate with other organizations that have separate funding streams • Payer provides RN case management support, easing burden on provider group
Many individuals in the target population do not speak English.	• Working with an interpreter means extra time to conduct Goals of Care discussions and to complete Advance Care Planning (ACP) documents • Extensive costs for interpreter services	• Hire bilingual staff to reduce need for interpreter services • Track the time required to complete ACP documents and similar time-intensive tasks, to support effort estimates (and appropriate payment) for this task

Factor or circumstance	Implications: what this may mean for the provider organization and cost of care delivery	Options / solutions
The payer has requested very stringent disenrollment criteria (e.g. as soon as a patient stabilizes).	• Frequent assessments to confirm continued eligibility • Brief duration of enrollment • Confusion among referring providers and patients/families	• Negotiate broader criteria • Negotiate minimum number of months for initial enrollment • Consider tiered services and payment for stable patients vs. active or unstable patients vs. frank disenrollment
The eligibility criteria are numerous and specific, requiring access to lab values, test results, and chart notes detailing care plans and patient preferences.	• May require significant education of referring providers • May require significant effort in screening and enrollment steps • May be very small volume or short timeframe from referral to death, at least until referring providers become familiar with the criteria • Providers may stop referring if many or even several referred patients are deemed ineligible	• Partner with payer and clinic/medical group leadership to identify the most effective and efficient methods for marketing services • Negotiate for start-up support, to offset low enrollment and revenues while referral base is being built up • Payer develops method using claims data and RN case manager to pre-screen and verify eligibility for all referrals • Coordinate with other programs, such as complex case management, to ensure that all patients in need, even those who do not qualify for PC, have access to some extra support
Other population issue (specify)		

Factor or circumstance	Implications: what this may mean for the provider organization and cost of care delivery	Options / solutions
SCOPE OF SERVICES		
The breadth of required services exceeds the capacity or training of the provider organization, which has not formed collaborative relationships with other organizations in the service area.	• Provider team works in isolation from other service providers in community • Provider feels responsible for meeting all patient needs • The provider tries to do everything, but is not compensated for doing everything	• With support from payer, provider forms collaborative relationships and partnerships with other service providers in the community • Set limits for the PC team
The payer-provider partnership wants patients and families to have 24/7 access to PC providers.	• Paying the palliative care clinical team to be on call may not be feasible	• Teach patients/families to recognize when symptoms and distress are starting to escalate, for earlier intervention • Provide 24/7 call only for subset of high-need or high-risk patients, or for limited periods • Leverage existing hospice staff to triage off-hour calls
It takes a long time to orient and educate patients and families about PC services.	• First month or two of enrollment requires additional time per visit to re-explain services • Reduced visits per staff member per day	• Develop or revise written materials to align with literacy level, language preferences, and cultural perspective of population • Partner with individual with whom patient has trusting relationship (primary care providers or case managers) to do orientation work before enrollment • Assign this task to community health worker, trained volunteer, or other non-clinical staff
Other scope of service issue (specify)		

Factor or circumstance	Implications: what this may mean for the provider organization and cost of care delivery	Options / solutions
CARE MODEL		
The payer mandates a minimum number of in-person visits per patient per month.	• High cost per patient per month • Some patients may not make themselves available for visits at predictable intervals, which reduces revenues for provider	• Negotiate other approaches – contact via phone, other media • Suggest high-frequency initial phase followed by maintenance phase • Create process to waive requirement for certain patients
Payer mandates that patient be seen in the home by a physician or NP at least every other month, regardless of patient status and needs.	• High cost per visit	• Negotiate criteria and supporting processes for this practice (active symptom issues, identified by standardized symptom assessment tool administered by RN) • Allow both video and in-person visits
Other care model issue (specify)		

Factor or circumstance	Implications: what this may mean for the provider organization and cost of care delivery	Options / solutions
COMMUNICATION EFFORT		
The provider culture is to have frequent Interdisciplinary Team (IDT) meetings.	• Potentially increases communication, problem-solving, use of standardized practices • Reduces the amount of time available for direct patient contact	• Limit these to frequency really needed to deliver high-quality care • Substitute other methods for promoting intra-team communication, such as texting throughout day • Hold some meetings using video technology (Skype, Zoom, Facetime) to reduce travel time
Payer requires provider team to participate in frequent meetings to review cases, verify continued eligibility and rate, etc.	• Ties up leaders (admin, medical, etc.) in meetings	• Develop criteria that limit case review to a subset of enrolled patients • Use audit process instead of concurrent review to verify eligibility
Other communication issue (specify)		

Factor or circumstance	Implications: what this may mean for the provider organization and cost of care delivery	Options / solutions
OPERATIONAL		
Payer is unable to help to identify potential patients.	• Provider team will spend considerable time educating providers and marketing services • Actual number of referrals may be dramatically lower than number of eligible patients	• Negotiate assistance from payer in identifying appropriate patients • Quantify effort required to generate and screen referrals; incorporate into negotiated price • Partner with medical group leadership to promote and incentivize appropriate referrals
The provider devotes considerable effort to securing authorizations for DME, prescription approvals, refills, etc.	• Ties up clinical staff on the phone; repeat requests are often necessary	• Negotiate exception to some rules while patients are enrolled in PC • Identify single point of contact at plan or within medical group to handle some requests • Develop plan with practice/medical group for facilitating authorizations for enrolled patients
Payer requires provider to report program and outcome metrics that are laborious to produce.	• Provider staff devote extensive time to data management and extraction tasks • Clinical team tied up in data collection that does not enhance patient care	• Negotiate different measures and metrics • Document time required to collect and analyze data, to support effort estimates (and appropriate payment) for this task
Provider must generate considerable data/documentation to support ongoing authorization for services.	• Administrative leads tied up doing these tasks	• Explore options for electronic systems that can produce necessary data elements quickly • Negotiate up front that payer will reduce burden of reviews after good behavior during first months of contract • Consider waiving some authorization processes for PC patients
Other operational issue (specify)		